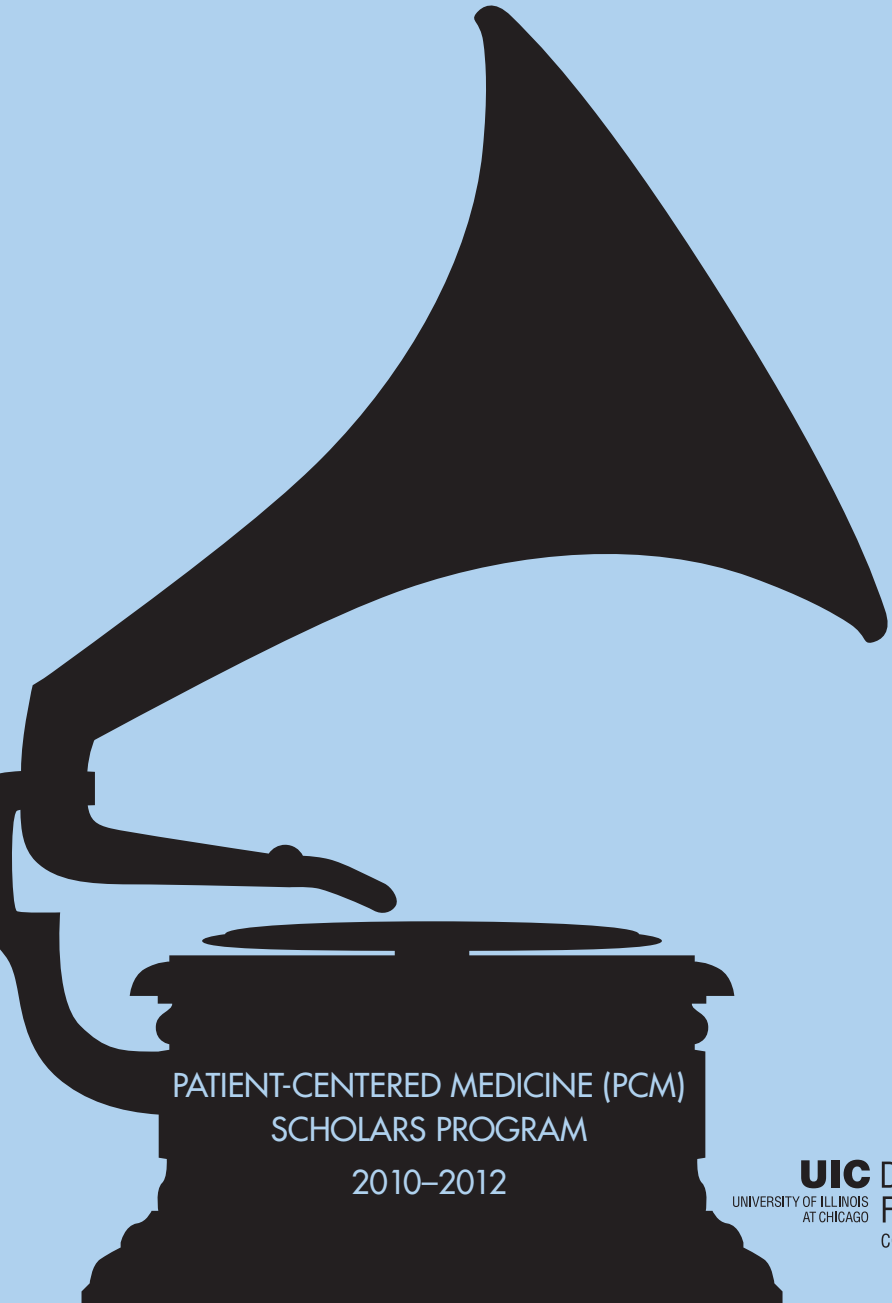
PCM VOICES

Reflections by PCM Scholars



PATIENT-CENTERED MEDICINE (PCM)
SCHOLARS PROGRAM
2010–2012

UIC UNIVERSITY OF ILLINOIS AT CHICAGO Department of Family Medicine
COLLEGE OF MEDICINE

PCM VOICES

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PATIENT-CENTERED MEDICINE (PCM)
SCHOLARS PROGRAM

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Note: *The views expressed in this publication do not necessarily reflect the official policies and views of the Department of Health and Human Services or the United States government.*

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This issue of PCM Voices is dedicated to all Program Faculty, Staff and Community Partners who have given their time, energy and wisdom to helping our learners grow and blossom into compassionate, caring and competent future physicians.

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foreword

Across the nation there is growing awareness that medical education in the United States is at a cross roads. Leading experts advocate that the changing needs of medical education require acceleration in the pace of change in order to prepare future physicians to meet the public's increasingly evolving needs and expectations. At the same time, there is a need to ensure that physicians have more background in population health and the role social factors play in effecting health change, as well as more frequent use of community-based learning settings.

Since 2007, the University of Illinois at Chicago College of Medicine has developed and implemented a longitudinal curriculum, the "Patient-centered Medicine (PCM) Scholars Program," which spans undergraduate medical training. The primary purpose of the curriculum is to equip physician trainees with attitudes and competencies likely to ensure that they can and will practice patient-centered medicine for all patients, including those who are vulnerable and underserved. Drawing upon the wisdom of great educators and philosophers, including John Dewey, Earnest Boyer and David Kolb, learning experiences are grounded in an "Education in Action" philosophy. Active-experiential learning, reflection, application and integration are vital pillars of the curriculum.

The curriculum includes a Service Learning Program that involves students in the direct care of underserved vulnerable patients in five concentration areas: Domestic Violence, Geriatrics, HIV/AIDS, Homelessness and Immigrant & Refugee Health. A central thread of the curriculum is students' ongoing involvement with selected patients, including underserved patients, over the course of their training.

The PCM Scholars Program at UIC is attempting to foster the development of critically reflective future physician scholars who will embrace the concepts of patient advocacy, humanism and compassion, and blend it with the art and science of medicine. Now in its fifth year, the program is fully integrated into the medical school curriculum. Participating students have reported the program as one of the best training experiences in medical school.

This collection of reflections is the work of medical students who participated in the PCM Scholars Program in the 2010–2011 and 2011–2012 academic years. It serves to remind us that medical education can be dynamic and inspiring and that our learners have great insight and wisdom.

Memoona Hasnain
Director, PCM Scholars Program
Editor, PCM Voices

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We are very grateful to all the students who contributed their writings for this publication. This unique educational endeavor by the Department of Family Medicine at the University of Illinois College of Medicine has resulted in a campus-community partnership, which is congruent with the mission of the College of Medicine and the University. It is an outstanding example of a curricular innovation that draws upon the passions and motivations of our students, the knowledge and expertise of our multi-faceted faculty, the unwavering commitment of our community partners, and creates learning experiences that directly benefit patients, particularly those who are most in need of health care. We are thankful to the Health Resources and Services Administration for their generous support of this educational endeavor. Special thanks to all our preceptors, partnering community agencies, faculty, staff, students, and patients for their participation in the program.

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****M4 Elective**

Reflections by M1 PCM Scholars

Musings on becoming a physician

Trust Me

The first year of medical school contains many new experiences, such as learning how to manage a heavy course load of basic science classes, along with interacting with patients and learning how to take histories. There are also a few opportunities for shadowing physicians, volunteering at free health clinics, and working closely with a preceptor as we start to truly see what being a physician is all about. These experiences begin to give us an idea of what kind of medicine we are interested, or not interested, in pursuing. I choose to participate in the Patient-centered Medicine (PCM) Scholars program because I believed it would teach me valuable lessons I could use no matter what specialty I choose in the end. I was mostly excited to be shadowing and working closely with a preceptor because I thought I could learn many tangible skills, whether it be taking vital signs, taking a patient's history, or even something else I would not learn in school my first year. I was also eager to start learning the thought process of a physician along with how to diagnose, manage and treat patients.

However, I have to say the most valuable thing I learned about was the relationship between the physician and the patient. I always desired to become a physician who provided quality healthcare but also impacted the lives of my patients on a personal level. I believe that the satisfaction of being a doctor comes not only from treating illnesses and saving lives, but also from developing relationships with patients from various backgrounds, cultures, and circumstances. I hope in the future to build a level of trust and comfort with my patients, which will allow me to best educate and treat them as a whole.

Even though I had formulated what I ideally thought a physician-patient relationship should look like, I never actually saw it until this year. What struck me and still amazes me every time is how much my preceptor treats his patients as individuals, like friends, like

family. He knows each and every one of them. On top of knowing about their health, he knows about their family and their jobs and their lives. He talks to them like they are his friends, but still with the concern and professionalism of a physician. He isn't just trying to quickly diagnose them and get them out of there. He takes the time to listen to what they have to say and he takes into account everything he knows about them when he comes up with a treatment plan.

You can tell the patients notice, because they treat him as a friend too, and they trust him completely. And because of this trust, all his patients trusted me as well, which truly surprised me. Of course patients trust their family physician; after all, he has spent time and energy building relationships with them. But they certainly don't know me. Yet in all my time at the clinic, only one patient said he didn't want a student in the room during his visit. Every other patient trusted me with their medical problems and their well-being and opened up to me. I even saw pap smears and abscesses and one patient even let me remove staples from his head knowing I had never done it before. This showed me just how much confidence patients have in a healthcare professional, even one in training, like me.

Watching my preceptor interact with his patients and seeing how his patients treated me showed me the importance of building relationships with patients. Patients trust us with their lives, and we need to treat them as a whole person and not just a series of diseases to cure. Being a part of PCM this year reinforced all my ideas about the kind of physician I desire to be. I hope that one day I'll have that same relationship of trust with my own patients as the ones I observed this year.

Susan Cheng
2010–2011 M1 PCM Scholar

Humility in Health Professionals

Walking in to my first visit, I noted the camaraderie and respect that filled the family medicine clinic. My preceptor greeted me with warmth and enthusiasm; making me feel just a tad bigger than the very naïve medical student I am. Her frankness and smile put me at ease. Following behind her footsteps and absorbing the interactions, I took home a lifelong lesson of humility.

During our first year, we are taught extensively about building rapport with our patients. Commenting about work or divulging common interests and hobbies are good starting points to establish a comfortable arena for the patient. As I observed my preceptor, I noticed that her complete trust in her patients set her apart from everyone else. She never expresses doubt, only thorough thought over what the patients shared with her even if it lacked scientific soundness, because she truly believes that whatever pain patients feel and however way they attribute it is true and worthy. This allows her patients to comfortably share and express their intimate secrets and concerns, even with me in the room. The trusting bond created between my preceptor and her patients made her humanistic care effective. Listening to her patients' stories and concerns, she used them as essential tools for achieving optimal care.

With the intensive training we receive as medical professionals, it is easy to assume that because we know the biochemical and scientific mechanism behind a disease, we know the disease better than the patient does. Watching my preceptor educate patients on diabetes and obesity, I noted that what she had was perspective. It wasn't just empathy: the idea of being able to see the patients' side of the block or point of view. What she exemplified was much more complex. She validated, comprehended, and acknowledged all dimensions of the block.

During one of my visit, a female patient presented with joint pain, which she attributed to her asthma medication and not to the 20 pounds she had gained over the last two months. Instead of measuring the worthiness of the patient's attributions based on scientific analysis and literature, my preceptor acknowledged the patient's concern and offered a change in medication. With the patient's concerns consoled, my preceptor artistically incorporated her concerns about weight gain and the possibility of that exacerbating the patient's joint pain.

This encounter was not about appeasing the patient, but about respecting the patient's understanding about his or her own body and encouraging a better understanding by presenting the patient with another dimension of the block. Achieving progress and sincere trust between the patients and the physician relied upon humility—the humble approach to viewing all possible explanations for the chief complaint, whether it be medically founded or traditionally based, as equitable ones.

Often times, it is easy to become consumed with the glamour and glory of medicine and lose sight of the main purpose of being a physician. Practicing evidence-based medicine can very easily lead one to attributing science as the ultimate right and solely founded way of treating patients. However, with my preceptor, I learned to never undermine my patients' feelings, no matter how seemingly different they are from my initial observation, but to search for a better understanding for those concerns. Lastly, I realized just how important educators our patients are to us. They complete our medical understanding and knowledge by sharing their traditional and culturally important ideas that we can then incorporate into our patient-centered medicine and care.

Ruth Hsiao
2010–2011 M1 PCM Scholar

I talk to my parents every Sunday. It's a tradition that I have stuck to ever since returning from the Peace Corps because I know that I never called home as much as I would have liked. As I've become older and reflected on the wonderful relationships that I have with my family, and the responsibilities that I have as a son and an older brother to three siblings, I'm happy to take the time to catch up every week. It's an obligation that I feel lucky to have.

However, it's eight o'clock on a Sunday evening and I'm frantically studying for the Biochemistry exam that I have on Monday morning. My cell phone has been blinking all day. I have been ignoring the text messages from my friends back home and have let my parents' weekly phone call ring through to voicemail. Now, when I look at the call coming through, I am reminded that my rapidly approaching exam isn't the only important aspect of my first-year medical school education. This is a call from my patient. Mr. B, my first and only patient, is on the phone and this isn't a call I can get around to later.

I stand up to leave the library and take his call, being careful not to disturb my frenzied fellow classmates. Mr. B is calling to tell me that there had been an accident. He had cut his hand on a bandsaw earlier that day and landed in the Emergency Room. He's back at home after a long day of treatment and is calling to ask if I would like to go with him to his appointment with the hand surgeon later this week. Of course I say yes; I feel honored that he has taken the time to reach out to me late on a Sunday evening given all that had happened to him today.

As I walk home from the library much later, I start thinking about the relationships and responsibilities inherent in being a good physician. Similar to the indispensable weekly phone calls home, good physicians have obligations to keep track of and to keep in touch with their patients. My obligation to Mr. B is one that I feel incredibly lucky and privileged to have.

Daniel Savage
2010–2011 M1 PCM Scholar

Looking back at my experience in the PCM Scholars Program, I'm beginning to see how difficult it can sometimes be to do the right thing for your patient. The very first patient I saw with my preceptor, Jen*, became my continuity patient. It certainly seemed like a good fit; Jen is a 39 year old woman with a long history of diabetes. At the time (and I am not certain if this is still the case), she had wanted to get pregnant but wanted to get her diabetes under control first. She seemed to like me in the clinic, and she thought it would be an excellent idea to have someone with clinical knowledge accompany her to all her appointments. I immediately informed her that although the clinical knowledge of an M1 is, to put it lightly, not much, I would do my best to answer her questions, or find an answer when she asked me something I did not know. She still seemed very excited by the prospect and was eager to begin our clinical journey together.

At the first visit, my preceptor asked her to have her blood work done, mainly to check her A1C. A week later, I returned to the clinic to be with her while she received the results. She was disappointed to learn that although her A1C had dropped over the past year, it was not low enough for a healthy pregnancy. That, factored with her age, prompted my preceptor to ask her to consider her options for having a baby. Perhaps this was the catalyst for why she hasn't retuned to clinic since December, or answered any emails or phone calls. Neither my preceptor nor I have heard from her since. Neither of us can do what's right for her, nor urge her toward a certain action.

For me, it was an eye opening experience. In school, we talk about patient compliance, and we talk about how the doctor can change him or herself to meet the needs of the patient, but it seems you have to accept that sometimes those needs will not be met. I believe my preceptor did an excellent job in taking care of her—she spoke to her in a direct, but caring fashion, and it certainly seemed like Jen responded well to what was being said. But she chose not to continue care, not to come to scheduled appointments, and not to respond to either of us. So, to summarize, what I learned through this process is that sometimes you can do everything right, but it may not always be enough. Instead, you have to find joy in the patients that do listen and do try.

* Name has been changed for patient privacy.

Jessica Kuppy
2011–2012 M1 PCM Scholar

The entire PCM Scholars Program has changed my naïve, narrow perspective about primary care into a much broader one that will hopefully help me become a better, well rounded, *patient-focused* physician.

This program has made me think of many questions I will face as a physician that I would not have otherwise have thought of. In fact, I loved going to the Lunch and Learn series, not only because I loved the fruit and walnut salad and spinach and tomato pizza, but also because the topics and discussions were so thought provoking and applicable. Each session rekindled my passion for wanting to become a physician, which the monotony and stress of class have worked hard to suppress.

For example, when do we ever learn about health insurance in medical school? Never. We are thrown into the medical system as residents and physicians and have to figure it out ourselves. Insurance adds another potential barrier to proper access to health care, and awareness of this issue can help us work around this barrier.

Getting to know my patient through appointments and phone calls was also a rewarding experience. I learned firsthand what my patient was thinking in regards to his medical treatment. For example, it is easy to be the physician telling a patient what he must and must not do, but how do you deliver that message effectively so that they will be compliant?

I learned the importance of rapport with my patient. My patient likely needs a right knee arthroscopy for his knee pain and walking troubles, but he decided against it because he did not like the orthopedic surgeon and did not want to take the time off to recover. If he had a positive relationship with the physician, he may have been convinced to go through with the surgery and increase his knee function in the long run. On the other hand, my patient has a

great relationship with my preceptor. He always says what a great doctor he is and I can see how that has positively affected him. Per my preceptor's request, my patient has joined a gym to manage his obesity, will see a nutritionist and, possibly, a physical therapist for his knee.

I also learned that there is a fine line in an interaction with a patient. You try to build rapport as best as you can with the patient, but at the same time you want to advise him on his health concerns without coming off as too critical. For example, my patient hasn't been the best at going to his appointments but I don't want to pressure him too much and risk losing rapport and the ability to effectively communicate with him. It definitely has been a learning experience. This can directly translate to difficulties any doctor faces with a patient. How does a physician effectively improve or remedy a patient's adverse lifestyle choices without being too critical or judgmental and losing all rapport? This is something that I think needs practice even for the people that are particularly gifted at interacting with patients.

There were many other lessons I learned through the PCM Scholars Program, but I could easily sum all of them up by saying that each lesson has taught me how to become a better patient-centered physician. I am coming out of my first year in this program with a broader perspective and a rekindling of my passion for pursuing primary care.

Mustafa Alavi
2011–2012 M1 PCM Scholar

Compassion and Responsibility

When I was brainstorming what to write, I realized that the PCM Scholars Program has enabled me to develop a real relationship with my continuity patient whom I shall call Mrs. L. This was a very welcome occurrence because relationship-building with patients is one of the main reasons I decided to go into medicine. And I also realized that I had come to gain a sense of responsibility for her medium-term medical care.

But first, I want to talk about a bad habit, I believe, we medical students sometimes develop while in clinic. I caught myself doing this until I had worked with Mrs. L for a few weeks. We, students, tend to forget that the patients we see have stories that are much larger and more intricately beautiful than their chief complaint. We tend to see them as "the guy who has hypertension and congestive heart failure" or "the lady with type II diabetes". But seeing Mrs. L has helped me remember that patients' lives are stories waiting to be discovered.

So, rather than continuing with a power statement of age, gender, PMH significant to CC, CC, and duration, I will first attempt to tell a little bit of Mrs. L's story, as I have discovered it in little nuggets. She is a polite, conscientious, witty woman with a beautiful smile and sparkling eyes. Even as she has aged beyond her years due to her conditions, she still dresses up to see the doctor and is a very expressive person. On one occasion, she brought my preceptor a stuffed animal and a card as a symbol of her affection for "mi doctora".

She has been widowed for a number of years but still wears her wedding band. She still obviously enjoys life and living. In short, Mrs. L is exactly the kind of woman we all would want for a grandmother. Serving her is a privilege for any medical provider. Mrs. L is also quite blessed in that her three adult children love her and take turns caring for her. Their solicitous care shows that Mrs. L was a very good mother. They are responsible and loving. They take initiative to help and protect her. Thanks to their care, Mrs. L will not finish the race of life alone.

She has diabetes type II and the rare Non-Alcoholic Steatohepatitis (NASH), a subset of fatty liver disease. Since she has had NASH for a long time, she now has cirrhosis and hepatic encephalopathy. Consequently, her liver has lost much of its functional capacity and she has to take a series of medications that together help her body get rid of the toxins that the liver

usually processes and neutralizes. But because of the encephalopathy, she can sometimes have an altered mental status and forget things. Here too, her children are a blessing because they keep track of her glucose levels, text them to my preceptor and myself, and make sure Mrs. L takes all her medications. Despite these serious conditions, Mrs. L has maintained a dignified feistiness and an admirable will to live.

Another topic I want to talk about involves medium-term care for a patient. We, medical students, also sometimes develop the bad habit of thinking that our responsibility for patients ends when they leave the clinic or when we go home for the night. Nothing could be farther from the truth and my preceptor has gently set me straight by her example. A couple months ago, my preceptor gave me a call in the evening to tell me that while she herself was on vacation, our patient Mrs. L had had an embolism in one of her legs. I was stunned and very worried. I felt like I was punched in the stomach. I wanted to rush to see Mrs. L but had to wait a couple days as I was out of town. That feeling of concern is healthy. It is called compassion.

Mrs. L pulled though, but now is taking Coumadin in addition to all her other medications. So, I resolved to redouble my efforts on her behalf, because I realized that she was truly partly my responsibility and that just being nice to her while she is in clinic was not enough. Since then, I have followed her progress by calling her children to ask about her. I also visited her when she was hospitalized for a fall and was able to explain the MRI process to her. My preceptor also had me create an Excel table with all her medications and their function to help Mrs. L and her children more easily keep track of them.

Finally, as I reflect back on my M1 year, I have discovered that the kind of compassion and sense of responsibility I have developed for Mrs. L is the kind of attitude I will need to have towards all patients I see from here on out. As a medical student, I may not be able to follow their stories or the progress of their conditions over the long term, but I must still treat them with a conscientious regard for their humanity, and always remember that their medical condition is but a part of the larger whole of their lives. When I finally finish my medical education, I will work hard to get to know my patients and to care, whether or not it happens to be business hours.

Sean Sales
2011–2012 M1 PCM Scholar

As physicians, we will often have too many patients to see and too little time. As medical students, we have even less time to spend with patients and at times lose sight of the fact that we spend all of our time studying now so that we will later be able to help patients. One of the biggest things that I will take with me out of the PCM Scholars Program is the fact that even with the busy lives medical students and doctors lead, I can never let my patients feel like I do not have time for them. Each patient has to take time out of his or her busy life to come to the appointment, so it's only fair that he or she get my full attention. The best way I can accomplish this is by taking the time to really talk with and listen to my patients.

Observing the relationship that my preceptor has with his patients and working with patients on my own, I have learned that showing patients I care and building a relationship with them involves listening to more than just their medical concerns. I often had some extra time to spend with my continuity patient and we would spend a few minutes discussing her family as well as what I have going on in school. Because of these brief conversations outside of her medical care, I feel like I have formed a connection with my patient. Starting off with a more casual conversation also made it easier for us to discuss her top medical concerns for that particular day.

One of the biggest lessons that I learned from my patient is that I can't make assumptions about how much medical knowledge patients have. My patient was born outside of the US and has the equivalent of a third grade education. Her education level alone would make it hard for her to understand a lot of information about her healthcare and this is further complicated by the fact that she never fully learned English. Despite all of this, she can remember her health history and knows what questions to ask about what could be wrong. At times I feel like she may even know more than I do because of all of the doctor and specialist visits that she needs to go to, as well as all of the required labs she needs to get in order to help monitor her medications.

All of my patient experience prior to the PCM Scholars Program was in Emergency Medicine on a college campus. So I never really thought twice about the importance of building an ongoing relationship with a patient. Spending time with my continuity patient has helped me to realize that this valuable skill will not only help me as a physician, but that it also helps the patient feel more at ease with the physician.

Tara Kennedy
2011–2012 M1 PCM Scholar

Insights on Patient-Centered Medicine

Patient-centered Care: A Reflection

You came into the clinic for a refill on your BP med.
I walked into the room reciting 'OLD CARTS' in my head.
Your Blackberry was out, armed with a list of things you wanted done;
I tried to keep up, making notes until I felt I had written a ton.

Soon I pushed it all aside and looked you in the eye.
I asked you how your day was and you let out a deep sigh.
I enjoyed our banter on non-profit orgs and wisdom teeth;
You soon revealed a new doctor was what you came to seek.

Diagnosed with diabetes a year ago,
You were struggling for a doctor who would just know.
That all you wanted was someone to care,
Listening to your concern, helping manage this scare.

My preceptor, your new doctor, you had not yet met.
I was sent beforehand to have a history set.
We spoke about past medical, family, and social.
I was hoping your comfort suggested you were hopeful.

Hopeful this visit would address your distress;
I wanted to ensure you felt free to express.
There were times you were tentative in your reply,
But I kept patience and warmth; to win your trust I would try.

I was surprised when you said you ate whatever you liked.
Perhaps it was why your blood sugar had spiked.
Pills were randomly taken from time to time,
Yet it was important to you that your sugar level did not climb.

I listened, I encouraged; your story meant more than numbers.
In return I learned how management differs across cultures.
It is crucial to consider family dynamics;
Patient beliefs are also worth noting in italics.

The doctor soon came for a complete run through.
Along with your health, she truly tried to understand you.
Another continuity patient I did not expect to gain,
But because of our connection, I could not restrain.

As you spoke with the doctor I began to understand,
The value of considering a patient's readiness for change firsthand.
Your understanding of medications was reviewed one by one,
Any questions or hesitations were addressed till there were none.

Briefly since then, we have discussed the idea of a written log,
Of a daily glucose check; perhaps soon enough a nutrition blog.
Patient-centered care has taught me more responsibility and diligence.
I endeavor to continue to work as a team in your progress from hence.

Neha Agnihotri
2010–2011 M1 PCM Scholar

My main motivation behind joining Patient-centered Medicine (PCM) Scholars Program was to gain some real world perspective. I think it's easy in our education to get lost in the weeds and often times we need something to help us keep sight of the bigger picture. This is the role that I was hoping the PCM program would fill.

My time in the program has been a rewarding one. I had the chance to work extensively with my preceptor and to learn from his style. I liked the way he walked into his patients' rooms and just talked to them. He wouldn't take notes in the room; he just focused on listening to the patient, trying to understand their story, their concerns and their needs. Patient-centered medicine, I learned, is about the little things.

Through my clinic visits, I tried to incorporate these attributes into my own patient interviews and it was really during a recent visit to a volunteer clinic that I realized both how far we had come and how much power we hold.

I volunteered last week at a free clinic near Devon Avenue that primarily serves the Southeast Asian population. Since many of the patients speak very little English, I helped not only translate but also take the histories and physicals. I think that speaking the language as well as trying to understand their full history really helped me connect with the patients.

One case in particular stood out in my mind. It was the case of a husband and wife that had come in together. They both had diabetes and hypertension but the husband was having trouble managing the diabetes. He was showing signs of neuropathy and retinopathy. The doctor recommended insulin injections. The patient resisted; he wanted to continue his original course of medications and promised he would do a better job of managing the diabetes.

I knew that the man was scared of using injections on a daily basis. Although the doctor had done his best to try and convince him to take insulin, the patient still resisted. As we were leaving, the patient asked me what I thought. I sat down with him and explained to him the risks and how he had already started to see some of the manifestations of diabetes. At the end of the conversation, his wife said "If you can ask the doctor to prescribe the insulin, we are prepared to start it".

That was a very rewarding experience for me and it happened again that day. The patients were asking for my opinion. It wasn't because I knew more medicine; neither did I disagree with the doctor's assessment. It was because I had taken the time to build a connection with the patient.

Sumanth Kidambi
2010–2011 M1 PCM Scholar

Faces Behind the Disease

Throughout our coursework, we learn textbook symptoms but rarely the face behind the disease. Medical school has bombarded us with biochemistry, physiology, history taking skills and anatomy, but our interactions with patients are very limited. Patient-centered Medicine (PCM) Scholars Program has given me the opportunity to talk to patients, learning their perspective about their life and disease. I heard incredible stories from many amazing patients. My experience with my first patient taught me the most important lesson; to see the person behind the disease.

I interviewed a 47 year-old female complaining of tinnitus and hearing loss. As a medical student, I have the pleasure of having extra time to just sit and talk with the patient. While taking my complete history, I spent some time talking to the patient about her life and concerns. She talked in a very loud voice, not being able to hear her own. Her daughter laughed at the loudness of the mother's voice and being able to joke around about this really helped break the ice between us. Since I asked about her concerns and also spent some time asking the daughter questions, I believe that opened her up to talk to me about her other problems. She stated that she hated talking to health care professionals because they always bothered her about these "other problems." She came with the same mentality during this visit—not to discuss them but only her ear problem. But after I built the relationship, I met the person behind the otitis media. We talked about her diabetes and hypertension, discussing ways to improve her blood pressure and sugar levels. Her heart opened to me because I saw her as a person, rather than the disease.

PCM Scholars Program has given me time with patients so that I could learn the essentials of building a relationship with a patient, allowing them to be honest and open. As I spend my next year sitting in the classroom, seeing the "face of the disease" is the most important lesson I learned during my first year of PCM.

Thomas Chen
2010–2011 M1 PCM Scholar

100 Walls

S.F. is 21 years old, in the youth and prime of her life.
She takes online classes to study early childhood education.
I learn that she used to have dreams of becoming a fashion designer,
Something she still hopes to achieve one day as her true vocation.

She has experienced abuse and violence in the past,
Yet I would have never known unless I had asked.

My patient is a married woman,
Yet she must live apart from her husband.

A few tears are running down her face,
As she explains to me why this is the case.

He had hurt her once in a fit of fury.
She hopes he will change so they can once again be a family.

She is a wonderful mother of 4 beautiful children,
Yet she wishes she had some more help every now and again.

While she used to hide behind 100 walls,
She now hides behind 99.
I realized that this is a wonderful start,
One step closer to learning what is in her heart.

Author's Note: *This program has been an excellent experience. While I hoped to use my knowledge and compassion to be able to help my continuity patient, I have learned so much more from my mentor and patient throughout the year. From the beginning, I had a very difficult time trying to get to know my patient. It was only in one of my most recent visits with her that I learned most of the information written in this piece. I realize that developing a meaningful relationship with our patients can be such a simple yet complex task, but once developed it will reward you 1000 times over.*

Khushboo Doshi
2010–2011 M1 PCM Scholar

The experiences I have had while in the Patient-centered Medicine Scholars program have helped me to better understand the broad landscape of the healthcare field, and hone the skills I will need to effectively communicate with diverse populations. An interaction with a very perceptive female patient, in particular, had a profound impact on me.

I had an enlightening encounter during a medical interview with an elderly woman from a low socioeconomic neighborhood who came in to discuss her diabetes management. She was able to accurately recall her daily medications, health tips provided by her doctors, and recommended dietary limitations. However, she also had high cholesterol and high blood glucose levels. I remember thinking, "This is obviously a well-informed woman who is fully aware of what she should and should not be doing. So, why is she holding on so tightly to practices that she knows could be detrimental to her health?"

But what I soon came to realize is that decisions about health are quite complex. Such decisions are not based solely on evidence-based research and clinical science, but rather are deeply embedded in culture and politics. Throughout the course of the interview, the patient expressed concerns about 'missing out' on her cultural traditions, and also seemed frustrated about living in a neighborhood with limited food choices and exercise opportunities which hindered her ability to heed doctors' warnings. At one point in the conversation, she actually said that she was angry—angry at a society that she felt did not care enough about her to provide her with the necessary resources to overcome her illness. The woman's words penetrated me, because the type of physician she yearned for is the type of physician I want to be—one that realizes that health issues have roots that extend far beyond any individual patient.

From this experience and several like it, whether it was following up with my continuity patient about setting up appointments with specialists, explaining the course of action with a patient, or participating in engaging conversations with colleagues about health care issues facing disenfranchised populations, I have come to find that all aspects of one's life are interwoven in health, and with each patient we have an opportunity to impact our overall community's health status.

As a participant in this program, I am encouraged that as a future physician I will have the know-how to complement the technical science of the field with a public health perspective that reminds me to consider how several, and at times, seemingly unrelated factors may interact and affect one's health. It is the ability to recognize such relationships that will help me to educate my patients on prevention, and craft successful, individualized plans of prevention, treatment, and hopefully, recovery with them.

Bryttney Bailey
2010–2011 M1 PCM Scholars

She Could See It in Her Eyes

My preceptor was asking questions of the husband, but she continued to notice the woman's hands tightly sitting on her lap, occasionally tip toeing into her purse to scavenge for nothing in particular. The man continued listing the medications he was taking, and the woman occasionally nodded and agreed. The husband pointed out some pain he had been feeling in his legs, and the woman hummed a quiet "yes" to corroborate how long the pain had been present. As the physician continued to type in the incoming information, the man mentioned to his wife that one of their children had called asking if they could baby-sit their grandchild later that afternoon.

Suddenly, the physician asked the husband if he might excuse himself for a few moments so that she could privately discuss something with his wife. She was her patient as well, and since she was there that day, they would do a quick check-up.

"Ladies stuff, you don't want to be here," the physician joked.

The man laughed and stepped out of the room.

The physician turned to the woman with empathetic eyes.

"So, what can you tell me?"

The woman sighed and admitted she had not been sleeping lately. She was feeling exhausted. Even though her children were older and preoccupied with their own lives, she continued to feel overwhelmed. She looked into her purse and then back upward. She said the name of a drug quietly.

"One of my friends uses it and recommended it. It's a sleeping pill. Do you think you could write me a prescription for it?"

The physician mentally took in the request and glanced over to her computer to think for a moment about how to respond. The medication the woman was asking for was not, in fact, a sleeping aid. It was an

antidepressant, which often came with the side effect of increased sleep. What was going on? The couple was in their 60's but looked like they were in their 40's. They exercised daily and had healthy diets. They often only came to see her for activity related injuries. Could this fit and very happy looking pair have problems at home?

"Well. This medication that your friend recommended is actually an antidepressant. It often also allows patients to sleep better. Were you aware of that?"

A few moments passed.

The physician asked what I did not think I, as a shadowing medical student, would have had the courage to ask.

"Are you feeling depressed?"

The woman answered that she was. She was having some new stresses. With her children settling into their own lives, and having recently retired from her job, she was feeling without exact direction.

The physician went on to explain more about the medication and ultimately prescribed it. The husband entered the room again, and we never learned whether or not he would know about the conversation that went on. Hopefully the woman's honest and open communication with the physician encouraged her to later reach out to her husband and let him know what she was going through. I know that the openness I witnessed from my preceptor will serve as a model for me long into my career.

There were many non-verbal cues.

And my preceptor saw it in her eyes.

Innessa Kipnis
2010–2011 M1 PCM Scholar

My Patient-centered Medicine Journey: From Desire to Implementation

My involvement with the Patient-centered Medicine Scholars Program has been inspiring, influential, and meaningful to me during my M1 year. This program has been an encouragement and a reminder to me of the reason that I chose to enter the medical field: the patients that I wished to help. Although it is easy to lose sight of this in the midst of tests and countless hours of studying, this program has been crucial in reminding me of my main motivation for choosing this path. More than simply reminding me, though, it has educated me and provided me with tools and resources to effectively help patients that I encounter. It has helped me to see that it really is not enough to desire to help, even though this is a great and necessary place to start. I must learn from others and educate myself so that I am prepared to help my patients in the most effective manner possible to positively affect their health.

Through the Lunch and Learn sessions, I have garnered more knowledge and sensitivity to issues such as healthcare disparity and health literacy. Through these sessions, which have been both thought-provoking and informative, I have also learned from my peers and their individual experiences. While with my preceptor, I have seen her compassion, knowledge, and skills come together to truly make an impact on her patients' lives. I have also been given the chance to put patient-centered medicine into practice while at the clinic and with my continuity patient. My continuity patient is an interesting, warm person and I have enjoyed getting the chance to work with her throughout the year. I will take away many things from the program this year. One of the most important is the knowledge and tools to more effectively practice patient-centered medicine both in my years of training and in my future career. I am so grateful for this opportunity and to all of the people that have made this possible.

Jenna Spencer
2010–2011 M1 PCM Scholar

The True Impact of Patient-centered Care

My experiences with the PCM Scholars Program have truly showed me the impact that true patient-centered care makes in enhancing the doctor-patient dynamic. My preceptor is a true exemplar of patient-centered care in action. He involves the patient in every part of the diagnosis and treatment; asking for the patient's input in every step. This helps the patient feel like a peer to the physician, and thus stay engaged in the interaction. My preceptor not only makes sure to get a thorough history of the present illness from the patient's perspective, but he also keeps the patient involved in what treatment to undergo. Before shadowing my preceptor, I had not seen a physician implementing a treatment plan that the patient chose instead of one the physician already had in mind. An important lesson my preceptor has taught me is that soliciting patient input, rather than just lecturing them, makes them far more likely to comply with the recommended treatment regimen. All in all, this ensures that the patient will get over their illness in less time, in addition to fostering a trusting physician-patient relationship and most importantly keeping the patient happy. These are just little steps that when implemented regularly make a world of difference in the effectiveness of healthcare.

Anisa Rahman
2010–2011 M1 PCM Scholar

I came into the PCM Scholars Program not knowing what to expect. I hoped that in the midst of all of the biochemistry and anatomy, PCM would keep my mind focused on the things that attracted me to the field of medicine in the first place. Working with my preceptor over this semester has been amazing. I have learned so much about the objective parts of the medical encounter; making logical conclusions to reach a diagnosis, listening to fetal heart beats, and understanding what the dark and light shapes on the ultrasound mean. I also learned a great deal about the subtleties of medicine; for example how to console a patient who is going through a hard time, how to deal with particularly difficult patients, and how to develop relationships with patients that transcend the typical doctor-patient interaction and move towards the interaction family members would have. We spend a lot of time in class talking about the doctor-patient relationship and how to make patients feel comfortable and willing to share their stories. The truth is that these interpersonal aspects of medicine are not easily taught in a classroom setting. Seeing the relationships my preceptor formed with her patients and forming some of my own helped me practice and appreciate the interpersonal relationship in a way that I would never have been able to in the classroom.

One of the goals of the program was to begin to appreciate the importance of continuity of care through following at least one specific patient throughout the course of the program. Unfortunately, I struggled a great deal with this aspect. The continuity patient I was assigned to seemed very excited to work with me at the beginning but slowly became more and more difficult to get in contact with. She not only stopped her interaction with me, she also stopped filling her prescriptions and scheduling her appointments at the clinic. The situation was very frustrating. My preceptor reassured me by saying all we can do as the physician is try to help a patient. The patient has to be willing to accept the help and hold up their end of the bargain in order for us to be effective. Even though my interaction with my assigned patient

was interrupted, I was still able to establish continuity with several other patients. Since I went to the clinic on Tuesdays around the same time of the month, I got to see many returning OB patients or patients that were struggling from chronic problems. I got to see the course of their illness or their pregnancy, meet their children, and hear about crazy days at work. I plan to use the interpersonal skills I learned during this first year of PCM as the foundation to build the rest of my clinical skills upon. I am grateful that PCM provided me a way to bond with my first set of patients in a way that other programs do not. It truly has made a difference in the way I see my future as a practicing physician.

Breana Taylor
2010–2011 M1 PCM Scholar

As I walk into a patient's room to begin a complete history, there is an excitement that spreads over me. There is a sense of nervousness too, but mostly a sense of excitement to learn about this patient and understand what they want out of their visit. Patients come in with a sense of trust and expectation of their physician, hoping they will be understood as a person with medical concerns. The excitement that fills me when first meeting a patient is the wonder of who they are as a person, what they will tell me and explain to me to understand them as a person and their reason for a visit. Perhaps I will not see eye-to-eye with them about certain life decisions, or perhaps they will have a background very different from mine, and belong in a different religious, socioeconomic, and cultural setting. But the excitement that fills me is about finding how to connect with them on a level that they feel they can approach their physician, or me as a medical student, and in an environment of trust and understanding to determine a diagnosis and plan.

The anticipation described here is an area I have been able to explore through my participation in the Patient-centered Medicine Scholars (PCM) Program. Throughout our Lunch and Learn series and the opportunities to observe and learn from my preceptor, I have further come to investigate how to create an environment focused on the patient. Entering into a physician-patient encounter, with the patient at the epicenter, can be difficult to do but is something I am continuously learning is of utmost value.

My favorite part of working in the PCM program this year was getting to see this patient-centered practice modeled by my preceptor. Working with him throughout the year afforded me the opportunity to see a physician that cares deeply for his patients and strives to help them improve their health and navigate the health system. The majority of my clinical observation and learning was at a clinic offering services to a lower socioeconomic demographic of Chicago. I truly enjoyed this exposure as it helped me to further learn about the difficulties patients have in navigating the health

care system with limited resources. Issues of money were very real for these patients, specifically considering lab tests and referrals to specialists.

All of these experiences in PCM have driven me to want to learn more and continue on this path of a patient-centered philosophy. At the end of the day, I think I owe it to my future patients as a physician-in-training to value them as people more than simply "another patient in line." As I consider what I have learned thus far, I can only hope to continue increasing my medical knowledge through my study of the basic sciences but also of my "people knowledge" and to continue to value people and learn how to best connect with them as patients.

Ann Bruno
2011–2012 M1 PCM Scholar

Teachable Moments

"A mentor is someone whose hindsight can become your foresight."—Chinese proverb

We've all shadowed physicians. As first year medical students, it is all too fresh in our minds the assorted opportunities we sought out to get some kind of hands-on clinical experience as we scrambled to put together a resume reflective of our desire to be doctors. But, this was the first time in my life that I entered into a clinical scenario where I thought I would be more than a passive observer.

I quickly learned that this was in fact the most important observational role I could occupy at this juncture in my educational path. As a first year student I come equipped with a severe lack of clinical knowledge juxtaposed with my strong desire to learn. My preceptor in the PCM Scholars Program has showed me the importance of the doctor-patient interaction and how vital it is to develop the skills necessary to be accessible to patients in many different ways.

A memory that I will reference for a long time, as a yardstick for measuring how I have connected with my patient, is from a day that I spent in the hospital with my preceptor rounding on patients on the Family Medicine service. The day was essentially over and my preceptor decided to check up on a few patients before heading out for the day. One of the last patients we saw was an older African-American gentleman who was recovering from brain surgery after a severe stroke. The following is my recollection of that encounter:

"Hi, I'm John*. I'm one of the physicians taking care of your loved one today." *Can we stop right there?* Have you ever heard a doctor introduce themselves as not doctor? I feel like by the time we complete all of our training, we wear our title of 'doctor' not as a badge of honor but rather a triumph. Maybe it was unintentional, maybe it was not, but I realized that in knocking on the door and simply introducing himself by name immediately put him at the level of the patient and his family. It made him immediately accessible. My preceptor also took the time to introduce me to the family and ask if it would be okay if I stepped into the room. They were more than happy to allow that.

There were 3 family members visiting the patient, who was wavering between states of consciousness and he was not able to interact at all. At that point, the doctor would probably not have much to do, right? But my preceptor inquired about how the patient was recovering from surgery and the family related that they were unsure how he was doing because he had been in and out of consciousness. What happened next was nothing short of a teaching moment for life. My preceptor proceeded to relate to me how difficult it can be for a family when they are going through a recovery process from such a major surgery, especially when the course of recovery can be so varied. He addressed me but also engaged the family in the conversation and they could be heard expressing hushed agreements and nodding along as my preceptor conversed with me. He then turned back to the family who had been listening to him with rapt attention and asked them again if they had any other questions. One family member echoed some of the sentiments the doctor had shared.

It was amazing to see how he was able to express the uncertainty of the situation for their loved one in such a creative way, without robbing them of hope or promising too much. By the time we were ready to leave the room, the patient's visitors were wishing me the best of luck in my career and relating that they had a niece who had similar aspirations. Before we left, my preceptor thanked the family for allowing us to speak with them and noted that someone would check in with them again shortly.

The lesson I learned from my preceptor is that, as physicians, we will have an urgent responsibility not only to treat patients but to effectively interact with the environment around them. In that conversation there was nothing my preceptor did directly for the patient, but he reinforced the support system that will be vital to this patient's recovery; something that is integral, albeit indirectly, to the patient's health. In that moment, he transcended race, gender, age, ethnicity and socioeconomic status.

It is of great surprise to me to know that no matter how much we prepare and study, it will only be with time and an active desire to improve that we will come close to delivering optimal care to our patients. I think I now have a greater understanding of why we practice medicine.

** Names changed to protect privacy*

Shama Patel
2011–2012 M1 PCM Scholar

Patient-centered Medicine is changing medicine by making the patient a part of the medical team treating his/her illness. Through my experience in the PCM Scholars Program, I have seen how important it is to carefully communicate with every patient. Developing individual care is an essential function to that communication. Doctors treat humans, not machines, so we cannot use a mechanical formula for every person that arrives at the clinic and expect the same results. We have to consider different treatments for different individual patients because of the unique attributes they bring.

From working with my preceptor, I have seen that no matter how busy the clinic is, it is essential to fully focus on the patient in the examination room. Treating patients with genuine interest creates an atmosphere that makes the patient feel comfortable and willing to communicate information that may be important. I believe I have seen patient-centered medicine at its best; when it is truly a conversation and valuable information is gained from the patient. I have seen this to be especially true for patients who have chronic problems (hypertension, diabetes, etc.); it is essential that they understand and partake in the treatment plan. If patients do not understand or practice the treatment plan, it will most likely not work.

From my experience in observing patient treatment, I believe there is a difference in what I would label ideal medicine and real medicine. Ideally doctors should be able to spend more time with their patients to discuss what they have been doing and how their plan is working in a relaxed manner. Unfortunately, in reality there is not enough time to effectively carry out all of the practices that would be ideal. A method I have seen my preceptor use is to invite the patient to understand that treatment is a partnership. Instead of using a generic treatment plan, my preceptor comes up with a plan what will work best for the individual patient. I have seen that it is important to be flexible because each patient will not respond in the same way. To ensure the patient does understand and take part in

the creation of the treatment plan, my preceptor would have the patient repeat back what the plan is and what they are going to do before the next visit.

I have been able to put some of this into practice with my continuity patient. Together we have been able to get her blood sugar at a more stable level by recording her levels in the same notebook every time she checks it, which helped her see how some of the other symptoms she feels might be related to her blood sugar levels. This has been effective and has given her the motivation to keep her blood sugar levels low and stable. We had to work as a team to make this work. But it is important to realize that this particular strategy may not help every patient that has diabetes. We have to work with the patient to understand where they are coming from and what will work best for them.

These techniques are also important for chronic diseases and pregnancies. Any time the patient needs to be in consistent contact with the doctor, it is essential to have a strong relationship that encourages open communication. Both the patient and the doctor should have a plan that they have worked out together. This empowers the patient by giving them a better understanding of their illness and the appropriate treatment. Giving the patient his or her own chart to fill in is an effective way I have seen this done. By having an organized table with their own notes, patients are able to see when they need to come in, review what they talked about last time and discuss any other important information.

Patient-centered Medicine is more than a doctor being pleasant to their patient. It is a way of empowering patients to be part of their own treatment and using individuals' differences to give them the best care.

Natalie Bodmer
2011–2012 M1 PCM Scholar

Through the PCM Scholars Program this year, I was given the opportunity to develop a long-term relationship with my patient. Before this year, I was not aware of how positively patient-centered medicine impacts patients. It was interesting to see how different doctors interacted with my patient. It was also saddening to realize how one of her physicians was not willing to listen to her story and, more importantly, made assumptions about her treatment. The more my patient tried to defend herself and explain her situation, the more adamant the physician became. This resulted in my patient being less compliant, especially after the physician realized his mistake but still did not demonstrate any empathy. My patient felt incredibly helpless and became less motivated to fight her addiction. Unfortunately, my patient has had multiple experiences like this, which she found incredibly frustrating. She had taken the initiative of acknowledging that she had an addiction issue, but it was disheartening that some physicians were not recognizing this and not supporting her.

My experiences with my patient made me realize how patients can feel trapped in the healthcare system. Amidst navigating between multiple physicians and different treatment regiments, she felt encouraged by the few physicians who actually listened to her story and demonstrated genuine concern. From a patient's perspective, it is frightening to have to navigate this system and not be respected but be unable to change physicians due to lack of finances. This represents a sense of powerlessness patients feel, especially those who are challenged by healthcare disparities. As a result, this has motivated me more to learn how to incorporate the patient's background and needs before making unnecessary assumptions.

Rachna Rawal
2011–2012 M1 PCM Scholar

Learning from patients

A Complete Examination

A trembling hand, a shaking touch,
A little look that means so much.
They shuffle into pristine rooms,
Their future right before them looms.

A woman with a bad sore throat "feels like [she's] swallowed knives,"
A man who encountered angry bees is now covered with red hives,
A child with an earache so painful he can't help but cry,
An expectant mother worrying her blood sugar is too high.

The charts upon the patients' doors give just a short report,
Of chief complaints and size and weight, of how tall or how short.
As they lean against the paper sheets that lie on exam beds,
Patients' bodies are like novels, waiting to be read.

The mere sight of one white coat sets their weary eyes aglow,
Just a single hand reached out to them and relief begins to show.
There are secrets, there are struggles within the ill, upon the maimed,
There is loss of independence, a life waiting to be reclaimed.

Their stories of their illness do not stop at body pain,
They talk of lost jobs and new accomplishments, their disappointments and their gain.
They speak of how insurance blocks them from good care,
They talk of medication costs, much too heavy for them to bear.

The physical exam is next, and it's a journey of the two—
The doctor and the patient, both discovering anew.
As they learn from one another, they begin to understand,
About the body and the friendship, about the power of a hand.

The cold hard press of stethoscope against a patient's chest,
Shows the patterns of a beating heart and puts them to the test.
Head maneuvers confirming vertigo cause a patient's eyes to shake,
A swollen foot that pains on touch shows signs of a bad break.

As a student looking in at this blossoming bond of care,
I am invited into this privileged group, the responsibility to share.
The patient is willing, they encourage me to learn,
They offer up their time and trust, giving me a turn.

And in those small white rooms, I see mothers, father, a best friend,
They are more than cases, more than bodies to observe and fix and mend.
They are stories, more complex, with physical and emotional hurts to treat,
For without the discovery of both, the exam is not complete.

Ivy Abraham
2010–2011 M1 PCM Scholar

Trusting Patients

"You're too far gone, you should be dead already," is what the doctor said to her. She describes him as a man whose eyes were distorted by his glasses. Oddly, she says that her daughter who accompanied her was more upset by this comment than she was. She tells me that she will never go back to his office again.

She and her husband have several chronic conditions. So she has been through the health care "system," as she calls it, several times. She has been hurt by many in the system in the past and she carries her scars, both emotional and physical, with her. When I first sat down to talk with her, she stared straight ahead, avoiding all eye contact, almost as if looking at me would be letting me in too much. Eventually, as we kept talking, she began to make eye contact with me for brief periods, and I could feel a little of the wall coming down.

She makes full eye contact with my PCM preceptor. Considering her past experiences, it is understandable that her primary care physician, my PCM preceptor, is the only doctor she really trusts. One consequence of her mistrust of other doctors is that she takes prescriptions she gets elsewhere and brings them to my preceptor to check them. Because of her several chronic conditions, she is on multitude medications, but she doesn't take all of them. My preceptor asked about each medication and the reason why she hasn't been taking them. She did not take a few of the medications because she did not know the reason they were prescribed. When the reasons were explained, she agreed to take them. When she refused to take one medication, my preceptor did not force her to take it, but instead accepted her decision and discussed alternatives with her.

My experience with this patient and the PCM Scholars Program as a whole has shown me the importance of a good doctor-patient

relationship. When the trust between a patient and physician has been violated, it can be difficult for the patient to follow advice from physicians and it can have a negative impact on their physical and mental health. In this case, although the patient would be described as medication non-compliant, which suggests that she is the one at fault, it is at least partially caused by her previous experiences. Explaining the reasons behind the medication and accepting the patient's decision on one medication built trust and respect between the doctor and the patient. Observing my preceptor over the course of the PCM program, I have been able to see the positive impacts of a good patient-physician relationship that is built on mutual trust and respect.

Elizabeth Shay
2010–2011 M1 PCM Scholar

The Waiting Room

For most of us, before the onset of any sudden or serious medical complication, a trip to the doctor simply means a checkup, a bad cough, or a curious mole. They're quick visits, usually with a small pack of antibiotics and bedrest as the worst-case parting words. When chronic diseases are discussed, it's usually in reference to some distant relative or a character on television. The waiting room is seemingly harmless. And from the physicians' perspective, there's a certain flow of patients throughout the day. It's always busy, no down time, just a flurry of new faces to extend a helping hand towards. They walk past the waiting room for maybe 10 seconds out of their entire day.

However, once a patient's circumstances change, once they begin to encounter chronic problems, the intersection of their story with that of the physicians' morphs as well. Time spent in the waiting room, which can be in excess of an hour, starts to become an evermore daunting experience. It's difficult enough to navigate the health care system, even without this nerve-racking preface to the visit.

PCM has placed me at that intersection, where I am graciously allowed the perspective of the busy physicians as well as that of the chronic patient. It's been a very unique experience having both of these lenses, and I am very grateful to have the privilege to look through them almost simultaneously.

Shadowing my preceptor throws me in full throttle, as we transition from room to room, from patient to patient, each with a unique story, a unique puzzle to be solved. Then we met my continuity patient, who has chronic gastric and muscular aches. She's young, at an age when chronic problems should not yet be afflicting individuals. But as fate would have it, a traumatic accident caused the sudden onset of issues she must battle on a daily and hourly basis.

Waiting rooms have become her new watering hole. They're no longer simply for common colds. They're where hours are spent, wasted from her life, instead of spending quality time with her loved ones, or relaxing with a fun hobby. They're where her mind is allowed to roam; contemplating

what could possibly be the next issue with which she must battle. The room isn't like the physician's, where there is no down time, but rather there is more time than anyone should prefer. She then finds out that she has to be referred to yet another specialist, and wait in yet another waiting room. Navigating the medical system can become frustrating and draining.

This bleaker outlook is an easy rut to become entrapped in, but my patient has displayed surprising strength and optimism. She hasn't expressed consuming frustration or anger or any excess level of angst. My patient has impressed me, and inspired me. Her waiting rooms are a lot brighter than I would have expected, considering that she must see at least five different specialists, working them into her work schedule ever so carefully.

It is by no means easy to balance all of the demands that a chronic health problem imposes on one's life, but there are ways to manage them. Having been able to see both sides of the coin through PCM, I will definitely say that there is a way that one can indeed muster inner strength with a solid enough support system and a stable state of mind. So this has challenged me even more: if a patient can have this much strength in the face of all these issues and they're willing to put their undying faith in the health care system, this speaks to the extraordinary responsibility that is incumbent upon physicians to their patients. In order to show respect for that faith and courage, we must continually show exemplary character and dedication to improving our patients' health outcomes. From my experiences thus far with my preceptor, both by witnessing her interactions with patients and hearing their unelicited feedback about her when she leaves the room, I am confident that that is exactly what I've been fortunate enough to be a part of. Their waiting room seems a little less gray.

Aaron Goldstein
2010–2011 M1 PCM Scholar

My First Patient

Ms. W was never one to show weakness. She exuded an air of poise and unwavering confidence from the moment she set foot in the clinic. As a new patient, she provided the perfect opportunity for a first-year medical student to practice complete history-taking skills.

Her past medical history revealed a whole host of chronic illnesses that she was dealing with. Although well informed of her health condition, she admitted to rarely taking her medications and to often eating unhealthy foods. Ms. W gradually uncovered more about herself as the interview progressed. She had been a victim of abuse. She was a cancer survivor. She had gone through a divorce and was currently living alone. Her most recent hardship was dealing with the murder of her son, and it was evident that she was still nursing the fresh wound as she recounted the details of the incident.

Yet despite living a life filled with adversity, Ms. W maintained a positive outlook on life and I could see such great resilience in her. What impressed me the most was how she used the strength that she found from surviving hardship to help others. Ms. W was most proud of her job as a Child Protective Services case worker. It soon became clear that her dedication to the needs of others often caused her to neglect her own. Therefore, it became my primary goal to help Ms. W place herself at the forefront for once.

Over the next few weeks, I had trouble contacting Ms. W. I worried about her every time I heard her cheerful voice on the automated voicemail greeting. Little did I know, the anniversary of her son's death had just passed and she was experiencing great difficulty in dealing with the pain of the loss. She tried to persuade me that everything was fine, although I could see how vulnerable Ms. W was underneath the tough exterior. I wanted more than anything to

erase her pain, but all I could do was listen and provide words of comfort. It turned out that this was all that she needed. Because she rarely sought help from others, I saw how valuable my role as an emotional support system was to her.

In the following days, Ms. W began to feel better and we started to work on ways to improve her nutrition and health. We researched recipes together and identified simple exercise techniques that she could try. I was elated to discover that Ms. W had adopted a few beneficial lifestyle changes and wanted to continue making additional alterations. Not only have my experiences with Ms. W shown me the positive impact I can have on a patient's health as a future physician, but I have also been given a glimpse of how rewarding it can be to have the privilege to enter the lives of our patients. I am most grateful that Ms. W shared her life's story with me and I am humbled by the fact that she trusted me enough to help her at her most vulnerable moments.

Stephanie Wang
2010–2011 M1 PCM Scholar

To encapsulate what I learned into a short narrative, I think, would be entirely insufficient. This program teaches what can never be taught through textbooks, and what it does teach comprises the determining factor between 'a doctor' and 'a good doctor.' For this year, I have been working under an incredible physician, my preceptor (who falls in the 'good doctor' category), at a Federally Qualified Health Center (FQHC). On my first day with my preceptor, it became obvious that she has an incredible capacity to earn the trust of her patients in a short amount of time. In my first visit with a patient, I stood in a room with a mother and her daughter for what was initially a school-required check-up. My preceptor started the conversation as any physician would: "How are you? What brings you in?" But by the end of the visit, she managed to extract the daughter's concern about getting pregnant, a hidden history of baby-sitter abuse, and intimate details that otherwise would have only been shared between mother and daughter. This was all accomplished within 10 minutes. As the visit ended, my preceptor informed me that this mother would be my continuity patient.

That day, I made it my goal to learn how to earn trust as quickly as my preceptor. My patient struggles with multiple conditions, including congestive heart failure, morbid obesity, and type-2 diabetes. When I met her, she was entirely unmotivated to adopt a healthy lifestyle. Following this patient has taught me so much about the importance of knowing what really matters to a patient. In the process, I also learned how to navigate the Illinois health care system as an uninsured individual. It is with pride that I can say that my patient is now more rigorous about visiting her doctors. She now regularly checks her blood-sugar. In the last month, she also lost ten pounds.

My patient and I have been talking over the phone on the weekends, discussing her diet and her overall health. I was not sure if my house calls were helping her or becoming obnoxiously

persistent. Two days ago, she came into the clinic. After her check up, I asked her if she would like to continue our weekend conversations. Without skipping a beat, she replied "yes!" It was a moment where I felt validated and that I learned something about the art of doctoring. It has been a privilege to work with my preceptor and the PCM Scholars Program. Working in the direct service of the uninsured and underinsured at an FQHC and following one patient has been a rare experience.

Sonny Patel
2010–2011 M1 PCM Scholar

I was a bit apprehensive when my clinical preceptor and I met Mr. W, an elderly, powerfully-built man, with a bald head, but a full beard. He was the perfect candidate, with a history of Type II diabetes, for the continuity patient I would assist with during appointments with his physicians and provide resources and counsel for outside of the clinic. But more importantly, would he like me? Would he appreciate my company during his doctor's appointments? Or would he just be irritated that someone 40 years younger would be advising him on how to manage and care for his life? And what could I, as a first-year medical student, help contribute to Mr. W's medical care?

Mr. W agreed to allow me to act as his medical student advocate and we began to discuss his life, his family and his medical issues. Although I was a bit nervous around him, my fears disappeared as I heard him crack a hilarious joke about his upcoming marriage. From that point on, I became much more comfortable and we were able to build a solid rapport and establish a plan to improve his diabetes.

After my initial visit with Mr. W, I accompanied him to visit his endocrinologist. We discussed Mr. W's high glucose and HbA1c levels (long-term indicator of glucose), diabetes-related retina problems, renal failure and other associated conditions. I also learned more about, understandably, his difficulties with managing so many different diseases at once, and the difficulty, as a clinician, in advising a patient to comply with a multi-dimensional treatment plan. I would have been sympathetic to the endocrinologist if he was a bit frustrated with Mr. W's trouble with his diabetes management. Instead, the physician had Mr. W focus on one new goal before the next appointment: eating similarly-sized meals at the same time every day. At the next appointment, the new goal was to start exercising regularly. This really opened my eyes to the importance of prescribing a treatment or medication, but implementing it in a way that it would be centered more on the patient, leading to better compliance.

As time went on, I became more aware of ways I could assist Mr. W in managing his condition. For example, I helped suggest going to a dietician and attending diet courses to control blood sugar levels and weight. After attending a few appointments and courses, and learning how to start a more balanced, low-carbohydrate diet, in conjunction with

starting to lift weights, Mr. W has seen significant decreases in Hb1Ac and has lost about 15 pounds.

The waiting room of a clinic has been, to me, the least favorite part of going to visit the doctor. But it was there where I feel I learned more than I ever could in the patient room about Mr. W as a person and what he wanted to accomplish by controlling his diabetes. I found out he loved watching hours of sports and was thrilled when he was able to see Derrick Rose at the United Center. I learned about his fiancée, his children, and his brothers, and how he had a blast during Mardi Gras in New Orleans with them. I learned he wanted so badly to keep his diabetes under control so he could have more great times like these.

"Medicine is the easiest part of being a physician," a doctor once said to me. It is easy to prescribe a course of chemotherapy to a cancer patient, but heartbreaking to inform a patient's family of his/her passing. It is straightforward to recommend a diet, exercise, and medication plan to a diabetes patient, but it is much more difficult to counsel that patient in a way he will comply. These non-medical aspects of being a physician, which are not emphasized in the curriculum the first two years of medical school, have been the most important lessons for me during my time with Mr. W. Instead of simply going to the clinic, seeing new patient after new patient, and treating them like puzzles to solve, I was able to follow a patient over the course of several months, learn about his life and aspirations, and from there, provide a more personalized level of care. As I continue my medical studies, I will always remember that behind every patient, there is a story to be told. And, sometimes, all it takes is just that extra little effort to listen.

Dawen Zhang
2010–2011 M1 PCM Scholar

The Art of Medicine

My patients have taught me something new, something you are unable to find in a book or in a science lecture.

My patients have taught me the art of medicine.

My patients have taught me empathy. Empathy which allows me to see the world as someone who is suffering from kidney failure.

My patients have taught me fear. Fear of being admitted into the hospital, and not knowing what tomorrow will bring.

My patients have taught me compassion. Compassion which will allow me to be a physician who does not treat the disease, but treats the patient.

My patients have taught me frustration. Frustration that results from not being able to control your glucose levels.

My patients have taught me the true meaning of appreciation. Appreciation of your health and well-being.

My patients have taught me happiness. Happiness which comes out of being healthy enough to witness the birth of your granddaughter.

Most importantly, my patients taught me how important it is to see medicine through their eyes.

Nicole Diaz
2010–2011 M1 PCM Scholar

Growing Up

All my life, I have been a student. My role is a subservient one, where I humbly acknowledge and respect the wisdom of my elders. As a result, I have never truly felt like an adult, much less a doctor.

In many respects, my relationship with Mr. T was a teacher-student one. He was the teacher and I was the student. He told me about how he deals with his condition and in the process, I have learned to listen. It is a non-trivial task and one that I would need to learn and relearn.

As doctors, it is easy to tune out what the patient is saying and focus on that textbook case with the classic presentation of the disease. I would argue that the basic curriculum of most medical school cements this skill. Each day we are overwhelmed with information; being able to tune out and focus on the most salient facts hones our Darwinian fitness.

Mr. T was determined that I did not become another monkey byproduct of the evolutionary tree. My conversations with Mr. T gave me a very personal glimpse into how the body reacts to disease. Pharmacological interventions are passive agents while patients need to make daily adjustments in response to the body's physiological state. The latter has an emotional and psychological component that is inseparable from the mechanistic manifestations of the disease. None of this is outlined in the chapter on metabolic disorders, but for Mr. T, the non-biological implications are more proximal than the existence of faulty receptors or dysfunctional enzymes.

I was content being Mr. T's student, but Mr. T had other plans.

During interactions with Mr. T, he would force me to be the teacher. He would often stop in the middle of the conversation and ask me

to explain something or explore a possible diagnosis. Many times, I was pretty sure he knew the pathophysiology better than I did. After a few of these instances, I felt compelled to share what I had learned in class with him. As I delved deeper into my basic science studies, I had more questions for Mr. T, and together we would assemble our picture of how the disease affected him, a picture that does not exist in any textbook.

This was an extremely empowering exercise because I felt like an adult; Mr. T's equal. Interestingly, Mr. T thinks the same thing. It is ironic, he says, because most patients would tell you that they feel like they are inferior to their doctors.

I still have a long ways to go before being a doctor, but through this experience I have gained so much perspective and insight. I enjoy being a student, but now I see myself as a confident and mature woman who is mastering the skills she needs to be a better doctor.

Marion (Mengyuan) Liu
2011–2012 M1 PCM Scholar

I have learned a great deal from the patients I have had the opportunity to meet through the PCM Scholars Program. I have seen how the same illness can affect two individuals in extremely different ways based on their life circumstances, psychological health, and access to resources. I also now better understand how each medical encounter a patient has can impact the course of their care, not just due to medication they might receive or tests that might be run, but also in their perception and reaction to medical care and advice in the future. I want to share two lessons I learned through the following anecdotes.

The importance of a patient's life responsibilities:

As we talked, she repeatedly mentioned her great-granddaughter, even showing me a picture of the happy four-year-old girl. She had two main health concerns, type-1 diabetes and hepatitis C that led to a liver transplant 5 years ago. While her A1C levels indicated her diabetes to be well controlled, she seemed to struggle to keep up with her required doctors' appointments. Her work involves helping HIV patients to follow their regimens of drugs and doctors' appointments, which are even more rigid than her own. Of any patient, she would seem to be the one who could easily keep up with her medical plan. As I followed up with her in subsequent weeks, she was almost always with her great-granddaughter when I called. Her insightful questions about medical instructions, such as concerns about how she was to take a fasting cholesterol test when it was impossible for her to maintain her blood sugar at a safe level without eating in the morning or worries about the effects of medications on her transplanted liver, demonstrated her clear knowledge about her conditions. Despite her strong knowledge base, she still seemed to struggle with making the appointments she needed with specialists to ensure continued health. It readily became clear to me that her obligation to the younger generations of her family overrode all her internal knowledge and the input of medical advice. Knowing her has shown me the importance of

never labeling a patient "non-compliant" or assuming that they simply don't get it. The more likely root of their difficulties in following medical advice lies in their life story.

The value of asking patients questions that may seem difficult or embarrassing:

At the beginning of our conversation, she was not very inviting of questions and gave only curt answers. Nonetheless, I forged forward trying to get her to open up. When I asked about her obstetric history, I learned that she had had 3 abortions in her life. When she divulged this information, I could readily sense both her fear of censure and a sense of defiance in the face of anticipated judgment. Ironically, by asking her this sensitive question and responding in a way that accepted instead of shamed, I was able to connect with her and garner a great deal more information about her than I otherwise would have. I was also able to initiate a conversation about how she was not currently using any form of contraception, largely because she was worried that if she requested it, her history of abortions would come up. She had concerns about the effects the abortions might have on her future fertility that we were able to allay. She also expressed a strong desire to avoid further emotionally difficult abortions. That day, she left with a birth control prescription and hopefully a bit more trust in sharing her story with medical practitioners.

Melissa Bryan
2011–2012 M1 PCM Scholar

Laughter
Before I entered the room I could already hear it
You and your wife
The quintessential happy bickering married couple
He no exercise, what do I do with him?
I be good otherwise you say.
You chuckle, I chuckle, we all chuckle

Type II Diabetes
Blood sugar level: 136
A1c: 6.5
Foot check: excellent
Exercise/Diet: your wife, "he's terrible"
You, "that's what you say"
Laughter

One step at a time
15 min today
30 min tomorrow
You, me
We both commit to an exercise plan
Yea?
Laughter

So not passionate about exercise
Passion: Tropical plants
Wife: His plants have taken over our whole basement!
You: They're my babies
Laughter

Your personality, so huge,
Your vibrance makes you look not a day past 50,
though shockingly you had hit the big 7-0
But do remember to take that Metformin of yours
Maybe just maybe go biking with your wife one of these days?

Working on it, working on it
Laughter

End of visit
You: You better be here next time I be back no?
Yes
You chuckle, I chuckle, we all chuckle
Laughter, the best medicine

Christine Wang
2011–2012 M1 PCM Scholar

Realizations

A Reflection on a Diabetic Patient

Working alongside a primary care physician through the PCM Scholars Program exposed me to many of the challenges that physicians are regularly faced with when attempting to care for their patients. A particularly unsettling aspect of this experience has been the passive approach that many patients regularly take toward their own health. Although a strikingly high proportion of my preceptor's patients are diabetic, I was especially surprised to discover that many of them take few, if any, measures to ensure that their condition is being managed adequately. Of course, in a society where fast food restaurants grace every city block and stairways are abandoned in favor of escalators, it may understandably be difficult for some patients to maintain healthy diets and get sufficient amounts of exercise. However, it is a problem of a potentially far greater magnitude when a diabetic patient neglects to see his or her doctor for a span of several years.

During my visits to my preceptor's clinic, I encountered a handful of patients who, until that point, had not consulted a physician regarding their condition for an extended period of time. This understandably poses many challenges for physicians. For instance, how does one approach such an issue with patients without potentially further deterring them from seeking care? Thoroughly educating patients about their condition and the potential consequences of their inaction is critical, yet apparently not always effective. With a projection that by the year 2020 half of the American adult population will develop diabetes, this may become a growing problem which physicians will need to adapt to and develop new approaches for, in order to ensure that their patients are receiving the care that they need.

It is an unfortunate irony that in a nation where nearly 50 million people remain uninsured, many of those who do have access to health care neglect it when they need it most.

Mateusz Ciejka
2010–2011 M1 PCM Scholar

Opening Up

When I began this program, I hoped to learn more about engaging my patients in a productive dialogue about their health. I wanted to know more about their health in order to help them. It seemed simple in my mind. If I could do my job correctly, focus on their problems and ask the right questions, I would elicit their truthful responses and thus know how to improve their health. It sounds simple, right?

So I was a bit disappointed to find that after my first meeting with my continuity care patient, he was a bit distant towards me. He is a middle-aged Hispanic male and during my first meeting with him I also met his wife and daughter. When I walked into the room, I noticed that he and his wife were speaking Spanish so I assumed that the best course of action was for me to use the Spanish skills I have to communicate with him. I am not a native Spanish speaker but I have studied the language for the last nine years and I spent a summer immersed in Costa Rica. So I found it a bit frustrating that even though I spoke to him in Spanish he would reply in English. I was making an effort to be "patient-centered" by recognizing his cultural background and trying to accommodate it to the best of my abilities. Assuming that he was more comfortable in Spanish but was using English to make my life easier, I gave him the Spanish version of the program information form. After consulting with his wife he agreed to participate in the program and our student doctor-patient relationship began.

During our first meeting, we spoke of his past and present medical problems and he politely answered my questions, but almost always followed his response with a question about me. I would then try to politely, but briefly, answer and then direct the questions back to him. We played this game of verbal ping-pong for a good thirty minutes or so. He filled me in on his problem list but continued to either ask questions of me or offer recommendations on living a good life, on being a good parent, etc. It was an odd interaction, but being new to the world of HPIs (History of Present Illness), I thought little of it.

I began to worry about our trust level when he failed to show up for our second visit. I had called the day before the appointment to confirm the date and time and his wife assured me that he would be there. So the next day when a few hours went by and he still wasn't there, I felt confused. My

confusion only grew when my preceptor told me that it was the first time he had ever missed an appointment. I felt a bit embarrassed that perhaps he had skipped the meeting knowing that I would be there. The last visit hadn't gone poorly, but I certainly hadn't developed the rapport that I would have liked. It was as though there was a cultural wall being put up between us that somehow my language skills couldn't penetrate.

The breakthrough came during a phone conversation. I had been trying to get in touch with him for a week, but every time I called I either reached his wife, his daughter, or his sister-in-law. I would be told that he would call me back when he was available and I would leave my number for him. A few times I even called back "later" at the time specified by the person on the other end. But I couldn't reach him. So when seven days later I finally got through, it was a mixture of relief (I can get the responses to the questions my preceptor wanted me to ask for the last week) and confusion (Why didn't he call me back? Was he purposefully avoiding me?).

He explained that he had been working a lot and that his evening work shift and early morning trips to take his daughter to school left him little time to sleep and even less energy to return my calls. Partly placated, I continued with the questions I had been asked to get answers to. This time he actually had some concerns of a medical nature and I was able to follow the ECM (Essentials of Clinical Medicine) script: When did you first notice it? Has it changed over time? Does anything make it better or worse? It was as though I was finally getting somewhere with him. But the moment my line of questioning ended, his resumed. "So, Pat, tell me how school is going," he probed. I indulged and told him about the classes I was currently taking (actually missing, since I had called between classes and we had now been talking for at least fifteen minutes). When I finished he said something that surprised me. He said that it sounded like I was doing really well and that he wished his daughter would show the same interest in school. He then proceeded to ask if I would perhaps talk to his daughter about how important school is. It was the first time that he had revealed a sense of trust in me.

Our phone conversations continued as I played messenger between him and my preceptor. Although I couldn't get in touch with him for days at a time, I was relieved that it was more likely work and sleep that prevented us

from talking than an active avoidance on his part. But I was still concerned about the language component. Whenever his wife would answer I would have to speak to her in Spanish and she would summon him in Spanish, but as soon as he came on the phone it was all English. Curious, but unsure of how to approach the subject, I asked about his childhood and where he was from. It turned out that he was born and raised in Chicago, while his wife and sister-in-law were from Mexico. We continued talking and I eventually decided that the best course of action was to complement the quality of his English and ask which language he preferred.

It turns out, his preferred language is ENGLISH! He wasn't raised speaking Spanish and had to learn most of it after meeting his wife. I was stunned. I hadn't considered that he and I were coming from a very common background. We were both born and raised in the Chicago area and we were both learning the Spanish language. It turned out that when he was signing the consent form, he had to consult with his wife because he couldn't read the form!

That piece of information seemed to tear down the cultural wall that I had imagined was preventing our conversation. It was truly humbling to realize that in my haste to be able to check off all of the prescribed questions, I hadn't attempted to identify with him. I had been sensitive to my perception of his language, his culture, and his medical concerns, but I had been in control of the agenda. Every time he had attempted to converse casually, I had redirected to the professional topic at hand, and in doing so, prevented a normal flow of conversation. It was me, not him, who was being distant. And more than just being distant, I had also allowed my hurt ego to bias my opinion. While I realize that many patients will talk endlessly if given free reign over the conversation, perhaps I need to be more open to a different style of interview. So, in opening up my mind past the assumptions and barriers and allowing a style of conversation that is patient directed and student doctor steered, I am actually opening up a whole new realm of possibilities for connecting with my patients in a clinical context; ultimately, meeting my goal of improving my patient's health. All I have to do is open up my mind.

Patricia Troxell
2010–2011 M1 PCM Scholar

The Slippery Boundary

There is a line in medicine that I never realized was so fuzzy; its demarcations cannot be taught in the classroom, even with the best of teachers. It seems so obvious to me now. I used to constantly navigate this line as a crisis counselor; I'm not sure why I didn't make the connection between the two fields sooner. As a counselor, it seemed I always had one foot over to the right and one foot on the left, and occasionally I would hop to one side, only to be pushed back to the other side only days or even moments later. This line is the slippery boundary between the patient's independence and the physician's opinion.

I sometimes live in a fantasy world, where I see the patient and the doctor as one. I imagine myself solving a life puzzle with my patient. I picture us brainstorming in unison and the patient eagerly willing to work with me to build a plan of action for whatever health issues she is experiencing at the time. But the truth is, each patient is an individual, and every individual already comes to you looking at the world and medicine through their own lens. On top of this, they can only be expected to make life changes based on where they are currently falling on the spectrum of "readiness". The trick is learning where to draw the line with each patient and balancing the necessity to follow the protocol of the law.

I accepted the slippery nature of this unseen boundary on my first day of clinic work in the Patient-centered Medicine Scholars Program. A young mother came in with her newborn and three-year old little girl for a standard well-baby visit. While we examined the infant, the mother was complaining that her 3 year old was a "needy brat" and was yelling at the little girl to "Stop crying! And stop acting like a baby." I felt myself cringe watching this interaction and I tried to catch my preceptor's eye, without being obvious, to see what she would do next. My preceptor didn't say anything; it almost appeared as if she didn't even notice as she effortlessly glided forward with the physical exam. As the interaction continued, I could feel myself biting my tongue. My urge to express my opinion was nipping at my inhibition skills. I wanted to tell this patient that if she was simply more comforting to her child, the little girl would respond by behaving calmly and they both would benefit. But without stopping we continued onward, checking the baby's hip flexion, Babinski Sign, and skin condition. As I listened to my preceptor ask the mother questions, I began to notice that her responses were very defensive. She was guarding her privacy, and would retreat into a closed off attitude if asked something she perceived as too personal for a physician-patient

interaction. I pondered their exchange, keeping quiet, only asking questions relating to the pertinent clinical exam taking place.
After saying goodbye to the family, I eagerly followed my preceptor out of the exam room and into the little office where she would take notes. With questions about her thought processes literally about to explode out of me, my mentor turned to me and began to provide her explanations before I could even ask. She clarified how she chose to draw the line and keep from intervening too deeply. As she told me the patient's history, the ethical quandary became clear.

When the mother first came in to the office a few months back, my mentor began asking her the standard questions asked in a well-baby work-up. Friction between the mother and the doctor escalated quickly. My preceptor was able to pick up on a sense of anger behind the mother's defensiveness about her privacy. Therefore, she had to consciously weigh the consequences of intervening in parenting techniques or staying out of the matter. She decided that intervening too much at this early stage would result in the mother not bringing her baby back to the clinic. While the communication style used by this mother may not be the most effective at raising a secure and anxiety-free child, it could not be constituted as reportable abuse. The dangers of the children not receiving regular medical care due to a tense relationship and negatively-perceived medical experience outweighed any positive result that could come from intervening with parenting advice.

Watching the parent-physician-child triad, I was reminded that every patient, every family, holds their own right to independence, security, and personal views on life. While it will be my responsibility to advocate healthy behaviors, report abuse, and provide compassionate holistic medical care of the highest quality, it will not be part of my job to impose my own personal view points on my patients. Figuring out the patient-physician dance of compromise between promoting healthy behaviors and respecting privacy and independence will be a challenge in every healthcare provider's experience. I will continue to examine this slippery boundary line as I continue through my path in patient-centered medicine.

Author's Note: *With great gratitude I thank my preceptor for her thoughtful and unconditional dedication to treating the whole patient. I am honored to learn from her.*

Faith Rohlke
2010–2011 M1 PCM Scholar

Papez Circuit.

I walk down the blue and white hallway at a brisk pace. My shoelaces are coming undone and whip loosely around my ankles, but I don't stop to tie them.

Parahippocampal Gyrus. Entorhinal Cortex. Subiculum.

My mind whirs along at its usual breakneck speed, fed by anxiety and caffeine. With the mountain of material I need to learn in the next week, every minute matters. Every stray thought about the dingy grey clouds that peek through the hallway windows is a poor allocation of time, every closed-eye moment merely gearing up for the deluge of active brain-time the next day brings. Efficiency is my new best friend.

Fornix. Mammillary Body.

Picturing lecture slides with sweeping swashes of color highlighting neural circuitries, I almost run into the door at the end of the hallway. It's closed, but I can see people inside helping themselves to lunch and taking their seats. I flip my backpack over my shoulder and rummage around for my iCard. By the time I wrestle it out of my wallet to open the door, someone on the inside has pushed it open for me. I smile graciously, while silently chastising the universe for making me waste energy with my cluttered backpack. I make a mental note to organize it after my next exam and file it behind notes to do my laundry, to go to the grocery store, to fix my shower, to work out, to clean my room, to call my parents, and to find a summer job. The growing list sets off a rising panic, but I push it aside. I'll worry about it all after the test.

Mamillothalamic Tract. Anterior Nucleus of the Thalamus. Internal Capsule.

I'm still running through the circuit as I sign in. As I scribble my name on the attendance sheet, I feel a distinct flash of annoyance. I don't really have time for a one-hour talk on Patient-centered Medicine right now. I still have to go through 3 lectures, 2 chapters of the book, and the review questions before I'm allowed to go to bed. This lecture is going to set me behind. I dot the i's on the record of my mandatory attendance with more force than usual and turn with a sigh to the table with food. Well, at least there's lunch.

Cingulate Gyrus. Cingulum. Parahippocampal Gyrus. And we're back to where we started.

I sketch the pathway out on my napkin as I munch through a piece of pizza. A smiling doctor from family medicine has gotten up at the head of the large

room and started talking. I'm trying to figure out a way to sneak my neuroanatomy notes onto my lap when I hear him ask a question that brings me up short. "What is patient-centered medicine?" he asks. I find myself searching my brain for an answer.

Come on, you should know this. Didn't you write an essay on this to get into the program?

But that feels like ages ago. Before anatomy. Before biochemistry. Even before histology. I can't for the life of me remember what I had written in that essay. He has to repeat the question several times before anyone offers an answer. When the girl across the table responds, I'm still scraping around the inside of my skull for words to describe patient-centered medicine. Her answer is good; concise but insightful. Yet something is missing.

Before I can help it, I'm raising my hand and voicing my opinion on the definition, adding what I hope to be some color and shape to our groups' current description. Soon enough, I'm elbow-deep in a discussion of the merits of a patient-centered perspective and the potential challenges such a perspective can face in the stubbornly hierarchical society that is medicine. The hour is up before I can check my watch, even though the doctor speaking has only gotten through a handful of slides. All the students blink dazedly when he winningly apologizes for keeping us occupied up to the very last moment of our allotted hour and, like bees sedated by a thick smoke, it takes us all a few moments to begin to collect our things and leave.

I reach down to my bag and see my neuroanatomy notes laying right on top. I'm suddenly shocked by the solitude of my thoughts, which float around my mind unaccompanied by the self-deprecating rebuke that usually waits to greet me when I waste valuable study time. And I realize that the last hour wasn't even close to wasteful; it was revitalizing. In the last hour, I was transported back to the person I was when I applied to medical school—earnest, hopeful, and truly ready to make a difference. I was reminded that the purpose behind my vigilant cramming, late night reviews, and alarming caffeine addiction, was so that I could be the best doctor I could be - not for me, but for my future patients. I was, in that moment and every moment since, grateful that I joined the Patient-centered Medicine Scholars Program.

I smile as I slowly walk away from the room at the end of the hallway, notes tucked safely in my bag. I peek out the windows as I pass by and notice the grey clouds have given way to a brilliant beam of sunlight.

Nikita Vashi
2011–2012 M1 PCM Scholar

Coming Full Circle in Labor and Delivery

My first PCM clinical visit was a bit unorthodox. One of my preceptor's patients went into labor, and, rather than cancel and reschedule, we decided that I should come along for the ride at the hospital instead. I remember I was incredibly excited. I'd never been in the labor and delivery unit before as someone in the medical profession. My only previous experiences with that hospital department were the births of my three brothers. My preceptor expected her patient's labor to go quickly; predicting her to deliver by noon. Then, noon came and went. Then 2 pm came and went. While I was there, I figured I might as well learn some things related to obstetrics. I learned about APGAR scores to asses newborn health, terminology like gravida/para, how to measure cervix dilation with a chart, and chatted with various physicians, residents, and students throughout the day. Around 5 pm, it became clear that this patient was not going to deliver for a long time. As I'd been there since 9 am, my preceptor and I made the decision to end my visit and go home. Though I acquired a lot of knowledge that first day and felt that the visit was more than worthwhile, I was heartbroken that I missed out on my first delivery.

This story is important for me to tell because, in many ways, my first PCM visit mirrors the overwhelming majority of my M1 year—you're waiting and waiting for a life to begin. Only, in the case of the M1 year, that life is your own. I remember that at my White Coat Ceremony this past August, one of my family members congratulated me and said, "Well kid, today is the first day of the rest of your life". It felt that way; finally, after years and years of wanting to become a doctor, that journey was actually beginning. However, throughout the first year, with the endless supply of exams, labs, classes, and required readings, it is easy to feel like you are still waiting for your life in medicine to begin. The worst days usually consist of you working yourself to the bone and seeing very little, if any, return (not unlike spending a whole day in labor

and delivery, only to leave before the child is born). However, what I've found this year is that if you focus too much on the waiting aspect of life as a medical student, you can miss the reality that life itself is still going on around you. With waiting comes the opportunity for learning, whether it concerns something like the Krebs Cycle or tips to forming an amazing patient-doctor bond through the Patient-centered Medicine Scholars Program here at UIC.

My continuity patient in the PCM program turned out to be a formerly homeless, former drug addict who is pregnant. She is set to deliver in mid-April, about two weeks after I submit this reflection. I will be in the exact same hospital wing where I began my PCM journey almost a year ago. I will know more basic science, more clinical techniques, and more patient-centered medical skills than I did before. However, what will not have changed is the waiting that will inevitably take place… and with it, the opportunity to keep learning. Who knows? Maybe this time, I'll even get to be there for the delivery.

Lindsay Schwartz
2011–2012 M1 PCM Scholar

Working with the PCM Scholars Program and with my continuity patient was different than what I expected; it was challenging in many ways. It was actually quite a difficult process to meet with my continuity patient, and I ran into quite a few communication difficulties. However, I believe these difficulties taught me more than I would have learned if everything had gone smoothly.

My continuity patient was assigned to me specifically because my preceptor thought she would be a particularly good challenge for me. I am happy she had this insight because working with my patient taught me about some of the difficulties of working with patients, and taught me about the important role of the patient in the doctor-patient relationship.

This patient has a history of non-compliance. She often would cancel her appointments, and when it was recommended that she see specialists, it often took her several months to make the appointment. This was frustrating for me. In my naïve idealism, I think part of me believed that most patients would easily comply with their doctors' recommendations if they were simply approached correctly. Now I realize that, despite a doctor's best attempts to make a patient understand, patients have their own lives and concerns; often these other concerns end up taking precedent over a doctor's orders.

With my frustrations, I had to remind myself not to blame the patient, or to accuse the patient of not caring about her own health. I reminded myself that my continuity patient has a complicated life: she not only has to juggle several health concerns, but she also has a history of depression with sleep disturbances, and she plays a major role in the care of her grandchildren. I believe if I were in the same place, making appointments with my doctors would often be put off as well.

Of course, there is always room for improvement. If I were to do the year over again, I would likely take a different approach. I believe I might have called my continuity patient more often to check in on her appointments and health concerns. I was originally concerned that I would be perceived as intrusive if I called too frequently, but I think my calls might have helped this patient to understand the importance of making and attending her appointments. I believe I had a good rapport with this patient as well; perhaps I could have utilized our relationship to help her understand more about her health.

In the end, albeit frustrating, PCM was a positive experience. I learned a great deal about the vital importance of the doctor-patient relationship. I also realized the significance of the patient's feelings about treatment in their healthcare.

Erika Olson
2011–2012 M1 PCM Scholar

The classic 'poly' triad of diabetes symptoms are polydipsia, polyuria and polyphagia; one of the first classics among many I learned about in my M1 year.

I went into my clinic session excited and thinking, albeit naively, how I would be able to easily recognize these symptoms if presented by a patient, and that I may be able to help diagnose an elusive disease.

Lo and behold, one of our first patients that morning was a recently diagnosed diabetic. It didn't take long for me to ask him what symptoms he had noticed prior to his timely diagnosis. He mentioned how he had been gaining weight, constantly felt thirsty and had to take numerous breaks at work to use the bathroom. As we talked, though, I noticed how his symptoms actually came to be. He was a single father who was so focused on raising and supporting his teenage daughter that he forgot about his own needs in the process. How working as a janitor at a local high school he had to spend long, hard hours at work and, reasonably, felt ravenous when he reached home. How he didn't have time to cook every day and would resort to fast food or pre-cooked meals. How coaching basketball was his escape and passion in life.

PCM has underscored for me what it means to adopt the patient perspective, to understand the context every single patient brings in the encounter and beyond. A physician may have all the understanding of a patient's disease, but if he doesn't bridge the gap and incorporate the patient's outlook, lifestyle and beliefs, any plan is meaningless. This single father, for instance, hesitated to cook, despite knowing how, because of time constraints; yet, he immediately made time and started cooking when he realized his daughter may be at increased risk for diabetes. I have learned that diagnosis is only part of our interaction with patients; just as important is understanding the patient's story and going beyond the 'polys' they may present.

Puja Gopal
2011–2012 M1 PCM Scholar

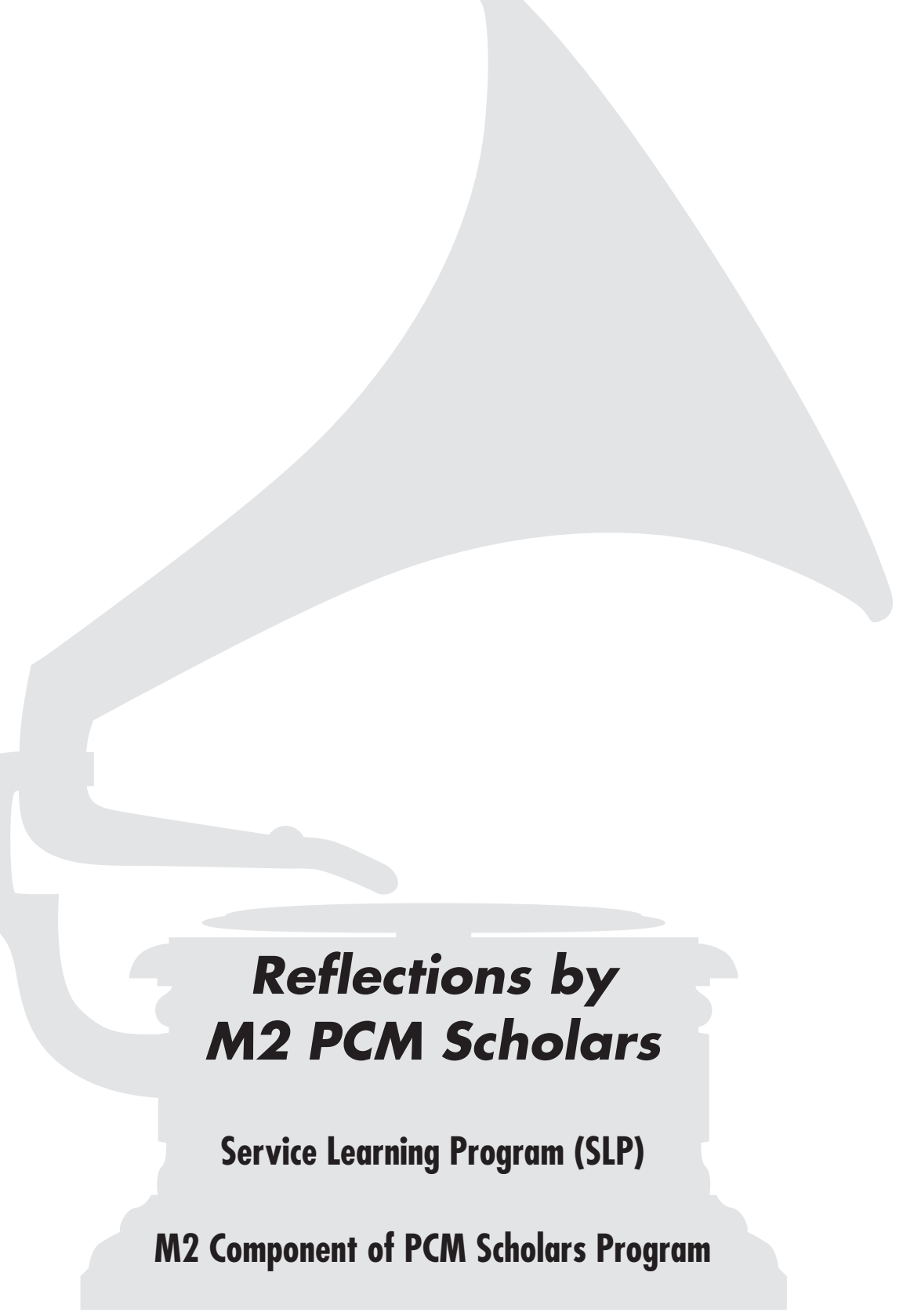
Open the door. Fake the smile. Say "I'm a first year medical student. Could I ask you some questions about your health and why you're here today?"

Then came the day that I opened her door. Excited to meet her, my new continuity patient, and slightly nervous about whether she would like me, I introduced myself and sat down. I was under strict instructions to avoid talking about her medical issues, so I shifted in my seat quietly, a little confused as to how to get things started. How was I, a young physician-in-training, supposed to get to know an older woman with chronic health issues quickly enough to find common ground with her? What would we even talk about? So I asked her name. Then I asked her age. And we began to talk about her life, her family and how she lives. Before I knew it, I felt like I was speaking to a friend or mentor, rather than a patient.

This is what the PCM Scholars Program and, more importantly, my continuity patient has taught me—never forget that patients are people. They may present to you as a clinical study with problems that are sometimes easy and sometimes difficult for you to fix. They may seem faceless and nameless in the realm of their diseases and health risks. But their visits with you are only small intersections within the bigger 'picture' that is their lives, just as each patient visit is only a small intersect of your bigger picture. There is a life each patient lives that you will never see or experience, a life filled with passions and regrets, family and friends. Though you may never see from a patient's perspective the way he/she sees things, you can come to understand how the perspective is formed. You can get to know the family issues, the struggles and hopes. You can put a name, a face, and a background story to the diagnosis of diabetes.

As a physician, I will not always have the time to sit down with each patient and chat for extended periods of time the way I do with my continuity patient. Despite this, I hope that I will always remember to see my patient's health in the context of who they are, not just what health problem they have. I say this because although seeing a physician is only a brief moment in a patient's life story, it is an important one. Continued good health is essential to a person's life story. Therefore, a physician should keep context in mind—that is, a patient's health in the context of his/her entire life. So, open the door. Give a genuine smile. Say you're a first year medical student. Get to know your patient.

Michelle Hwang
2011–2012 M1 PCM Scholar



Reflections by M2 PCM Scholars

Service Learning Program (SLP)

M2 Component of PCM Scholars Program

A patient is more than

A set of vitals, an X-Ray

A list of labs in black and red

A stack of medication bottles

A liver coming in

A box to be checked off

A nursing home transfer

A 25 y/o F G2P0101

A diabetic in room 16

A patient is

A person, a life, a story

Olga Cherepanova
2011–2012 M4 SLP Co-Tutor

Domestic Violence

Survivor

This woman sitting before me appears bruised by life's battles.
She seems torn apart by her father's words.
Broken by her lover's fists.
I scream out, 'How could you have done that to her?
Don't you see how beautiful she is?
Don't you see she doesn't deserve this?'
But they don't hear me.
They just smile their sweet smiles while she barely hangs on.
If only I could heal her soul.
But wait, I see a light.
I'm blinded by the strength shining through her tears.
She tells her story so others may learn and not fear.
She is so strong.
She is a survivor.

Melissa Preyss
2010–2011 M2 PCM Scholar

Working with the domestic violence concentration in the Service Learning Program (SLP) has been an amazing opportunity to more fully understand the multifaceted nature of violence. It has also been a means to figure out how the medical community can address this issue and educate society about the role doctors can play in stopping violent situations.

From the advocates and doctors who have trained us and allowed us to shadow them, to the patients and survivors who have shared their stories, this experience has been a privileged glimpse into an aspect of medicine and society too often hidden in the shadows. What has been shocking to see is how pervasive violence is—it affects our children, our schools, our neighborhoods and cities and it is not confined by race, class, or even gender. Anyone can be a victim of violence and our systems are not well designed to handle that reality. Even the many resources that the medical community can provide are not well understood by many providers, not taught to all students, and unfamiliar to most patients. In fact, just the idea that a doctor could be the person to confide in about violence is a surprise to many.

When it becomes clear that the problem is so widespread but so poorly handled and understood, it instills a real drive to educate yourself and learn what you can do.

As a part of our final presentation for the SLP showcase, my group interviewed a number of experts in the field. We spoke with a therapist, a doctor, an advocate, a survivor of violence, and (my favorite interview) a group of high school sophomores, all boys. We used the Chris Brown/Rihanna incident and ensuing survey of Boston teens about dating violence to start our discussions. Listening to a group of teenage boys talk about this incident was incredible. They had so much insight and at the same time so little idea of how or even if the medical community could be supportive to them. They also expressed a real variety of views about where the blame lay in

the Chris Brown/Rihanna case, giving us a chance to see how some insidious attitudes can be developed at a young age. Since one of our goals in doing our interviews was to gauge what people thought doctors could do for them, this was a perfect chance for us to sit down with them after the interviews to explain what we, as the medical community, could do if they were ever to experience violence. Our other interviewees also provided valuable advice about how to teach about this issue within the medical community and how to educate patients and adolescents about violence.

It was a small step, but I know that each member of the domestic violence concentration has learned immensely from our experiences. I only hope we can keep teaching and keep learning to work toward making domestic violence recognized as a medical issue and one that we need to be able to handle with sensitivity, empathy and skill.

Anne Jennings
2010–2011 M2 PCM Scholar

The cycle of violence, a concept to which I was constantly exposed to while learning about the dynamics of domestic violence, is a self-perpetuating tragedy. The victim in domestic violence is not limited to the person being directly assaulted but also includes the children and youth who witness it. That was the history of my patient: a very strong woman who grew up in a violent family; one in which her mother was constantly abused by her alcoholic father and she was also physically hurt by her own father.

Even after she moved out and distanced herself from her father, violence remained in her life. She found herself in an abusive relationship with the father of her two children. When I met her, she said "I went to the shelter because I was afraid things would get worse and I did not want my children to grow up like that." It is usually when the victims recognize the effect violence has on their children that they decide to seek help; such was the case with my patient. Leaving her partner and going to a shelter was not an easy decision for her to make. Although she was safe and had access to counseling resources, her whole world was diminished to a small room with a bunk bed that she shared with her two children.

Although my patient has never disclosed to me the details of the violence she experienced, she made clear the devastating affect it had on her family. After being at the shelter for a couple of months, she went back to live with her partner. Finding this out was shocking to me, as it was initially hard to understand why she would go back to the aggressor. She told me that she felt he had changed and that things were going to improve. I did not feel confident that they would, but I have learned from my preceptor the importance of not judging the victims. Instead, I was able to say that I was glad she felt that way but that if at any moment things were to change, she could seek help again. After learning more about her situation, I realized that even if she was not completely sure that her partner had changed, there were many issues that made her return, such as her undocumented status, her two

children, and the lack of a support system. She could only stay at the shelter for a limited amount of time, after which she had few options she could turn to. While this was frustrating to me, there was not much that I could do.

Meeting the aggressor during one of her clinic visits intensified my feelings. When I called her to the room, he stood up right away, determined to come with her. I had to stand in front of him to explain that the patient had to go alone at first, to which he asked, in a defiant manner, if there was a problem. I had to explain that it was the policy of the clinic. The experience of standing in front of an abuser and saying "no" was something I had never dealt with before. He was intimidating and, at that moment, I had a glimpse of what her environment possibly consisted of at home. To my knowledge she is currently living with him, but I hope she will reach out for help should she ever need to.

Yury Parra
2010–2011 M2 PCM Scholar

Individualized Care

I have learned so much this year in terms of patient care, especially with the Domestic Violence (DV) concentration. I have learned the importance of making the patient-physician relationship a partnership. Experiencing DV is something that is so personal and that affects so many aspects of an individual's health. When a patient disclosed an experience with DV, I felt extremely grateful to be entrusted with something so personal. This is truly a gift and a privilege.

I feel more empowered to help individuals that are experiencing DV because I know what questions I should ask and how I can make the patient feel more comfortable. At the same time, I also recognize that one of the most important things I can offer the patient is an open door. I want the patient to know that I am there for them in case they are experiencing DV or know someone who is currently facing this issue. The experience as a whole made me really appreciate each patient I saw as a strong, resilient and special individual.

My patient was a hard-working woman who had many responsibilities as a single mother. Domestic violence had deeply impacted her physical and emotional well-being and it continues to impact her current health status. She suffers from anxiety, mild panic attacks, constant aches and pains, as well as stress. She was concerned about her children witnessing the domestic violence her husband had subjected her to in the past. One of her sons was exhibiting aggressive behavior, as well as anxiety. This case gave me great insight into how DV affects multiple individuals and how it has a great impact on their health.

Another great aspect of this year's SLP program was learning the appropriate next steps to take when encountering someone who has faced or is currently experiencing DV. After assessing a

patient's situation, it is vital to cooperatively develop a safety plan. I think that each person's situation is different and it is essential for both patient and doctor to work together to individualize a health and safety plan.

I think that the experiences in this program have made me much more compassionate. I am able to establish rapport with my patients much more easily. I am able to understand the dynamics between patient and physician and view that relationship as a team. I am also much more aware of DV. As a future physician I will continue screening for DV because I know how important it is and that many physicians don't inquire about it. Overall, the experiences in this program have inspired me to strive to be a physician that cares about each patient individually.

Celeste Cruz
2010–2011 M2 PCM Scholar

All marriages have their ups and downs, right? At first it was just words...then I started feeling worthless, as though I were being emotionally wrestled to the ground. We had been married 21 years then, but in February of 2003, he hit and choked me. I remember losing consciousness. I can't remember from where I found the courage—I don't even know if I had it at the time—but I left.

I have a daughter who was 28 at the time and a son who was 35—they, as well as my church, were not supportive of a divorce. Everyone wanted me to forgive him; they told me he had changed—so I went back that June. At times he was kind, but even though he didn't hit me, his words were harsher. One night I awoke to him standing over me, threatening me, gesturing towards a knife on the dresser. I kept praying: "Please God, don't let him kill me. I don't want to die." I was so scared. What happened next was a blur. I remember finding a job and then leaving in August 2003.

It's been nine years. Since then I've lived with my mother. But I feel scared, nervous, and unsafe. My mother's house is only two blocks away from my husband's—yes, by law, we're still married. He would stalk me, drive by in his truck if I was walking down the street and threaten me or just keep his eye on me. The last I saw him was five months ago. I've learned to take routes to avoid him. It's really stressful though. My knee and back hurt a lot but I can't exercise anymore. I only leave the house when I need to.

I can't leave my mother; she's 80 and needs me. My grandkids stay with my husband when my daughter is at work. They can't live with me because it's too loud for my mom and I can't go over there because he may be there. Two blocks away but living here lets me see them. I have a home, but I feel homeless. I'm 52 but my dream is to have an apartment of my own, far away, where my grandkids can visit.

The above is a story from a domestic violence survivor. I worked with her throughout the year, but the patience, courage, and determination she taught me were far greater than anything I could offer her. I always thought I was a "good listener," but what it truly meant to be one surfaced every time I spoke with my continuity patient. She wasn't looking for advice, or even sympathy. She just wanted someone to genuinely listen.

Domestic violence is a vicious cycle and many times the patients themselves don't realize the depths to which they are caught in it. Despite their willpower, there may be other factors that don't allow them to escape. This can be anything from their children to having no other source of income to the hope that things would change because "even if things didn't seem right, I know he still loves; he always says he does."

Deciding to leave, I learned, was the last of a million steps. Finding the resolution to confront the issue, gradually gaining independence by learning basic life skills, or building a safety plan were smaller but powerful steps we could encourage, because ensuring patients left without any threat to their safety and wellbeing was crucial. For my patient, she was able to physically leave—but to only a few blocks away. It's easy to ask why she doesn't move farther, until I realize her responsibilities towards her mother and her inability to afford an apartment.

This year I've learned a good deal about screening for domestic violence. I finally began to appreciate the value of a thorough social history, even questions like: "What are your hobbies? Do you wear a seat belt? Do you own a gun?" The background patients are coming from, their lifestyle, their social support and environmental influences play an invaluable role on their health. Many survivors of domestic violence often present with chronic pain conditions and/or mental health issues, such as depression or anxiety. However, it's not readily apparent that these are attributed to their physical and/or emotional abuse. Patients may not understand that the control or violence they are experiencing is abuse, and if they do, they may not have the courage to speak up about it. However, as health care providers, we should have the courage to screen and ask, and to simply listen with a compassionate ear.

Neha Agnihotri
2011–2012 M2 PCM Scholar

The Story Within

This year, I met a wonderful woman who opened my eyes to her experiences and strength; here is her story in my words:

"I am 50 years old and whenever I think about my ex-husband and what happened last year I can't help but cry. It's very hard for me to even speak about it. All I know is that I don't even recognize my life anymore. I used to be so independent. I could get around when I needed to and worked so many different jobs. I have always been able to provide for my family from the time I was a child. Now my neck hurts, my arms, my back, and my knees hurt so much that taking the bus to get groceries is very difficult. I have 4 children and I worry about my youngest daughter; she seems to have been affected by what has happened. I have experienced many dark days where I felt there was nothing left in the world; I felt overwhelming sadness. But now I am motivated for the sake of my kids. I just wonder, when will this pain go away, when will our lives be stable again?"

Though she failed to realize her own willpower, I recognized the strength and beauty that she emanated.

Khushboo Doshi
2011–2012 M2 PCM Scholar

Geriatrics

Me and Mr. N.

Meet E.N; age 79 on paper but 16 at heart. Mr. N is an incredibly fascinating individual who is a very entertaining, walking and talking text on the history of Chicago. He knows all about the history of the city from the evolution of its parks and neighborhoods to the stories of its most famous movie stars and performance artists. In addition to his encyclopedic knowledge of the second city, Mr. N is also an incredibly skilled hair stylist and colorist who continues to work at a local salon in Rogers Park. However, Mr. N's interests do not stop there; he is an aspiring graphics designer, a connoisseur of early 20th century American cinema, and has taken up a new interest in neuroscience and the mechanisms behind brain functioning in the aging brain.

So as you can see, Mr. N is a man of many talents.

For most of his life, Mr. N has been involved in stage theater. He has been involved in this world for almost 60 years. As a matter-of-fact, his wife was a performer whose primary interests were singing and dancing. Mr. N spent much of his youth training in cosmetology so that he could help his wife reach her goal of becoming a world-famous performer.

Mr. N has extensive training in cosmetology, specifically make-up and hair, but his specialty is hair coloring. So if any of you in the audience are looking for tips on changing up your look now that the weather is changing, this is the guy to ask. He knows his color palette like the back of his hand.

Mr. N also operated his own small business with his wife in Evanston for many years until she passed on. Their store specialized in hair products and hair styling.

With such a rich experience, you may think Mr. N is ready to kick back and retire, but that couldn't be further from the truth. This vivacious individual is looking for another creative medium through which to develop himself, whether it be graphic design, writing or more extensive cosmetology training.

Mr. N's strong desire to constantly interact with his surroundings and be a part of the events going on around him is not only heart-warming to see, but also inspiring to watch as a future healthcare provider who will most likely be working with a larger proportion of mature patients. I only hope all of my patients can be as affable and entertaining as Mr. N.

My time with Mr. N has taught me a lot about aging in general and has really informed much of the previous experiences I've had with this more mature population, specifically with my own grandfather.

My grandfather had been a very vivacious person who was a very enthusiastic family man. However, after our grandmother passed away, he very steadily lost his zest for life and quickly became disinterested in many of the things which had previously given him much happiness and joy. As family members, it seemed that there was little we could do to get him out of his funk, and most of our efforts to encourage him to interact with his surroundings and be more involved with the world around him were fruitless. At the time, we had just accepted this outcome as a normal part of aging and loss.

I really wish that I had known Mr. N before my grandfather had passed on because I think he would have been able to convince my grandfather of all the worthwhile contributions he had the potential to make to the world. I think Mr. N is the picture of successful aging and the potential new beginnings that can come with getting older we could use as an example for our more mature patients. Though there are adjustments which come with age (some more drastic than others), it does not necessarily mean that all positive and enjoyable aspects of living are coming to an end, but simply that we must work together (family, clinicians, and aging patients themselves) to make sure that their lifetime of knowledge and experience does not simply go to waste but is used to contribute to the betterment of our society.

Meena Chelvakumar
2010–2011 M2 PCM Scholar

How the Mature Taught Me How to Think "Young"

Upon beginning the Geriatrics Service Learning Program (SLP) concentration, I must admit my apprehensiveness about entering an abysmal expanse of depression, and thus learning how to assist the elderly with depressive symptoms. These thoughts were affirmed after hearing about my patient for the first time: a 73 year-old mature male who had suffered a hemorrhagic stroke approximately ten years prior. I pictured a man that mirrored what I had witnessed for such a long time in my grandfather: a depressed man who had been so used to being independent, that a debilitating stroke plunged him into a deep dark place he could never get out of. Although we tried and tried to make him "better," nothing would ever bring my grandfather back from the depression and solitude he felt for the last years of his life, after two major strokes left him paralyzed.

Living through a stroke with my grandfather, I rushed to judgment about my patient before even meeting him. Needless to say, this was a mistake of grand proportions. Meeting "Ernie" quickly brought back feelings about my grandfather I never thought I would feel again. He had left side paralysis (like my grandfather), served in the Korean War (like my grandfather), and lived a totally independent, hard-working and proud existence prior to his stoke. However, he was not about to let his stroke define these golden years of his life. He was as feisty as ever, as proud as ever, and ironically, although wheelchair bound, as independent as ever.

Throughout our sessions, Ernie has taught me much. I have been his student in life, basically. He was so willing to share with me his thoughts on life, on the medical profession and on care for the elderly; teaching me that as physicians, we need to understand that mature people still have a full life to live. Their life is not done after a stroke. Yes, they are complicated cases, and yes they have tons of medications to take, but they also have tons of information to share

about patient care. They just require a tad more time in your patient interview, a more thorough history and more attention to detail than most patients. The most profound things I have learned are:

- When caring for mature patients, it is all about what works for them, and they often know more about what works for them than we do. When you do find what works for your patient, become their advocate.
- Taking care of mature patients is excitingly challenging. They often have complex medical problems and are on multiple medications, each of which can have multiple side effects or interactions. A thorough history is vital, along with investing the time to find the answers to their problems.
- Building a solid relationship with your patients is key. When a patient knows they can trust you to care for them, they become a member of their own medical team.
- I have learned how to better evaluate what is happening in the clinical setting and to, ultimately, be a better listener. Mature patients often have complex medical histories and each component needs to be taken into account to provide quality care.

I thoroughly enjoyed the Geriatrics concentration and truly hope it continues next year. I thank my preceptor for his guidance and for even suggesting the option in the first place. The mature population is so valuable to our society, but sadly is all-to-often forgotten by it.

Carmen Cancino
2010–2011 M2 PCM Scholar

Humility Is Key

Upon being assigned to the geriatrics concentration for the Service Learning Program, I had many misgivings. Geriatrics had not been my first choice. Although I had volunteered at a nursing home throughout college and had always enjoyed spending time with the "mature", geriatrics still did not seem like the most exciting or rewarding option to me. This idea stemmed from the host of negative preconceptions I had about the elderly prior to beginning this project. In my opinion, the elderly were, with a few exceptions, a depressed and lackluster bunch. They were often incapable of keeping up with what was happening around them and they were particularly unable to understand everything about their health and how to manage their disease(s). I felt the importance of providing good health care for the elderly, but I honestly did not think of them, as a group, as fully functioning adults. They were a population to be pitied and to be handled with care, almost like children. Reflecting now, I know that these were my thoughts, though I would never have admitted them at the time. Fortunately, I was assigned to the geriatrics concentration and was given the opportunity to discover how wrong my preconceptions were.

I had my first visit to the assisted living residence for low-income seniors where our patients lived in September. The resident director informed me that my patient, "Vincent" was a 63 year-old man who had been diagnosed with Lewy body dementia about 5 years ago. My first reaction to this was to feel pity for this man. I expected to find him a dejected or even angry person for the unfair disease with which he was burdened. Vincent, however, was neither of those things. Within two hours of conversation, I learned that Vincent was a proud Vietnam veteran, born on the South Side, who had worked for the city of Chicago for 30 years. He was a lover of music of all kinds; listening to it, dancing to it and singing it. He was once a member of the Nu City Mass Choir, a gospel choir that traveled around the country and world performing their uplifting anthems. He was a martial arts enthusiast who had earned a brown belt. Though his hands trembled and his gait was unsteady, he was bright and full of life and not at all to be pitied. After hearing about so many of his adventures, I told Vincent how impressed I was with his accomplishments. He replied, "Well, I'm not done yet."

I left that first visit humbled and awed by Vincent. Subsequent visits served to increase those feelings. I began to feel a little guilty because I was getting so much from our visits and learning so much from Vincent, that I wondered

what I could do for him. I knew he enjoyed the company, but I hoped to help him out in a more substantial way. I had the opportunity to do this, and to learn another lesson, when I accompanied Vincent to a specialist appointment. Knowing about Vincent's medical history and concerns, I was able to act as a liaison between him and his doctor. At the appointment, the doctor seemed rushed. He wanted to deal with Vincent's problem quickly and failed to take the time to talk to Vincent and understand all of his concerns. He recommended a solution that I knew would be difficult for Vincent to work with on a daily basis. I attempted to convey this, but the doctor wanted to try out the new thing. Without fully explaining to Vincent how to use this new device, he sent Vincent home with something that did not solve his problem but rather created more of a burden for him. This incident demonstrated the lack of communication that often occurs between a physician and a patient, especially an older patient. In this situation, I believe it was the physician's duty to listen to his patient and to ensure that he had taken into consideration all of the patient's concerns and the consequences and complications of a recommended treatment. He did not do this, and instead assumed that he knew what would be best for Vincent. It was frustrating for me to see a physician neglect a patient in this way. After this appointment, I asked Vincent what he thought of how he had been treated by doctors and health care workers, and how he would like to be treated. He told me that for the most part he had been treated well. I asked if he had any advice for future physicians, like me. He said, "You have to respect your patients. Try to understand where they're coming from." That incident and those words reinforced an invaluable lesson that PCM sessions had emphasized, but had never quite made real for me: to be conscious and respectful of a patient's right to autonomy, to make every effort to understand him and his unique situation and to treat him as a competent adult and a whole person. It was a reminder to practice humility which I will try to remember always.

Looking back on it now, I feel so fortunate to have been assigned to the geriatrics concentration. From spending time with Vincent to reflecting and discussing with my preceptor and the other members of my group and hearing about their experiences, I have learned much about life, about people, about aging and attitude, and about how to care for patients of any age. This has been an eye-opening experience and a great opportunity for growth and I am so happy to have my misconceptions abolished.

Rachel Guild
2010–2011 M2 PCM Scholar

A Mature Population

The reason I chose the Geriatrics concentration was because I wanted to be exposed to something that I wasn't very familiar with. I never met my grandparents on my father's side, and only met my grandmother on my mother's side. I thought the geriatrics option would be appropriate given my lack of experience with the elderly. My initial expectations were that I would have to face the issue of mortality, that it would be depressing and sometimes even monotonous.

I was really shocked when I first met my patient. He was enthusiastic, talkative, full of energy and very creative. As soon as I introduced myself, he put his hands up in the air and said, "Finally, someone I can talk Spanish to!" He started shaking my hand vigorously and asked me to sit. He was watching a soccer game and was very excited about his favorite team scoring. I was shocked at his energy level; I can't have that kind of energy unless I drink coffee! I thought I would have difficulty finding a topic he would be interested in, but instead I had difficulty keeping up with his conversation. He was very opinionated and had many interesting stories he wanted to share. I knew we would be spending many incredible moments together and I was excited about the following visits.

Each visit was different. He always had something new he wanted to talk about or some kind of activity he was interested in doing while I was there. He was very eager to learn and during one visit, he had me help him understand how to use a cell phone. He even wanted to learn how to text! During another visit, he wanted to play poker and when I told him I didn't know how, he rapidly grabbed his deck and said he would teach me. During our "poker game," he talked to me about a program he goes to on Mondays and Wednesdays. It's a Spanish program for the elderly, but he stated, "I don't really like going to the community programs. There's too

many old people there." I thought it was a funny comment to make, so I asked him to explain it in more detail. He said he enjoys the company of someone young because he is able to converse more and a lot of the "old people" at the program like to sit and watch television.

Spending time with my patient was one of the most rewarding and stimulating experiences I have ever had. His lively and cheerful personality completely transformed my initial thoughts of geriatrics. I never had a dull and depressing moment, and the issue of mortality didn't even cross my mind.

The aging population continues to grow and more elderly need physicians who are skilled to meet their unique needs. The geriatrics field is a challenging and exciting area of patient care that should not be misconstrued as "boring" or "depressing". In the geriatrics concentration, I learned the importance of treating the elderly as a vivacious group of unique individuals who deserve to be respected and treated as real adults, because they are real adults, just more "mature."

Yesenia Valdez
2010–2011 M2 PCM Scholar

My Mother

Poem written by my patient

The hardest thing I've ever known
Is my mother was put in a nursing home
They get her up early, tied in a wheelchair
With nothing to say
Her poor old eyes no longer can see
So she can't read the paper or Time magazine
I go and I see her as much as I can
I give her a bath and sit holding her hand
I hug her and kiss her each time I must leave
For the love that she gave me is not what she needs

Despite only spending six visits with my client, these visits were especially meaningful because they showed me the daily struggles of managing not only chronic diseases but also dementia. Initially, I questioned my role in our relationship, as from one visit to the next she had difficulty remembering who I was, and even less of our interactions. But with each visit, advances were made. I not only learned of her concerns, and thus was better able to serve as her advocate, but I also grew more comfortable and at ease with her. Although it was inevitable that her dementia worsened, she incorporated into her daily repertoire a few techniques, such as wearing her keys over her neck, marking the days off her calendar, and regularly leaving a pot of roasted coffee for her fellow residents. On one of my visits, she even taught me how to turn on and off her oxygen tank. Regardless of the fact that she was struggling with dementia and the memories of her mother who had Alzheimer's disease, she was still able to find ways to improve her life. I learned from her and we were able to mutually improve each other's lives with each visit.

My greatest challenge was learning how to be an effective resource for my client. It was not sufficient to simply answer her questions

about her living situation and her health. Instead, we reviewed her concerns regarding the changes in her life and implemented essential adjustments that worked around her dementia. My client taught me that patient education extends beyond simply being informed about one's health or options. Patient education must also encompass the skill set to refine and accommodate daily activities so that she can meet the needs of her current health status. Even though she will have no memory of me and will never realize the influence she has had on me, I will always be grateful for the opportunity to be a part of her life. I hope to carry along this insightful perspective into all of my future experiences as a lifetime patient advocate.

Ruth Hsiao
2011–2012 M2 PCM Scholar

This year I saw the geriatric population in a new light. It has always amazed me how much joy and wisdom this population possesses. I discovered that with the many complications and difficulties that age brings, this population is certainly vulnerable. Depression is unfortunately quite common. With an extensive list of issues including failing health, declining cognition and dementia, death of loved ones, facing one's own mortality, difficulty supporting oneself, and having to leave home behind, it is not surprising that this is so.

My patient taught me so many valuable things. While she has struggled with depression, I really felt that I saw her blossoming in the house (a residential facility for the elderly). Her gratefulness and optimism were so inspiring to me. The people there truly had become her family. The love and support she feels from the members of the house had evident positive effects on her. It reminded my why it is so important to have a support system to depend on, especially in the elderly years.

This year has reaffirmed my commitment to patient-centered care. I have always enjoyed the elderly population, and I feel that I now more fully understand the extent of their vulnerability. In the future, I plan to take this with me and to continue to explore the unique needs of the elderly population so that I can best serve them while always remaining open to the many things that they can teach me. In particular, I would like to always remember the mental health of the geriatric population. With the commonness of depression, I hope to always explore this vital aspect of health.

Jenna Spencer
2011–2012 M2 PCM Scholar

Looking Back

It is easy for us to remember the first time for everything.
The first time we went to school.
The first time we drove a car.
The first time we went to a foreign country.
The first time we had a birthday party.
The first time we met someone special.
There is a fluttering feeling of anticipation that is hard to forget.

But it is hard for us to know the last time for everything.
The last time we will go to school.
The last time we will drive a car.
The last time we will visit a foreign country.
The last time we will have a birthday party.
The last time we will see a loved one.
We don't realize it until it's over, and by then,
we have already moved on.
Every beginning has an end, and every first moment will have its last.

Edwina Chang
2011–2012 M2 PCM Scholar

97 Years of Life

90 years ago
You were just a young, carefree girl living in St. Louis.

80 years ago
You met and married the perfect man.

70 years ago
You were blessed with the gift of motherhood.

60 years ago
You dedicated yourself to being the best teletypist the government has ever had.

50 years ago
You transformed yourself into a talented painter.

40 years ago
You discovered your other love—playing tennis beneath the sunny skies of California.

30 years ago
Your hands became a bit shakier and you began to paint less and less.

20 years ago
You began collecting movies and mystery novels.

10 years ago
You moved to Chicago after your husband's death.

And now
You are known as the "tough ol' bird" living on the second floor.

Even though you prefer to keep to yourself these days, those who do get to know you better have the opportunity to hear your stories and advice which reflect 97 years' worth of wisdom and experience.

You have showed me the importance of being empathetic to the specific needs of the geriatrics population.
You have taught me how to be patient.
You have dispelled many of the common misconceptions of aging.

And to me, all of that has made you one amazing patient and teacher.

Stephanie Wang
2011–2012 M2 PCM Scholar

Lessons from Lidia*

Lidia is more than just a set of lab values on a page,
She is a person with interests, despite what you may think
about her age.
Her needs expand beyond just managing her psoriatic pain,
She has hopes and dreams, like visiting her home country
of Ukraine.

It isn't difficult to find out what she likes to do day to day,
A glance in the waiting room, and you'd discover her skills
in crochet.
You can still have plenty of time to tend to her diabetic needs,
It just takes a second to compliment her beautiful jewelry she just
made out of beads.

You can be more than just the doctor who removed her
endometrial tumor,
You could get to know her as a person, laugh and enjoy her sense
of humor.
You may even find you have some things in common, like wanting
to heal others,
She herself drew a poster, "Suture Boy," to cheer up her
hospitalized brother.

Lidia is not just a list of past surgeries, diagnoses, and medications,
Her history reaches far beyond that; it's a life full of
transformations.
Learning our patients' stories can help heal them and change
their fate,
In Lidia's words, "It's never too late."

* Name changed to protect patient privacy

Angela Jiang
2011–2012 M2 PCM Scholar

HIV/AIDS

One Story

At nineteen I learn I'm HIV positive.
More pressing: Coming out to my mom.
Now I'm unseen at home, and that's no way to live.
We were close, but now I am gone.

Five years bouncing around seeing how this life kills.
What about HIV? I'm still cursed.
I'm safe when I can be, and I hear there are pills,
but a bed for the night must come first.

Now I'm 25, and through two agencies,
I have a home and good personal care.
But one in three men like me has HIV,
and I know so few of us were prepared.

I would help if I could. "HIV!" in the schoolyards I'd shout.
I'd be the HIV poster boy... but my mom can't find out.

Sarah Anderson
2010–2011 M2 PCM Scholar

In the Patient-centered Medicine (PCM) HIV concentration, over the course of the year, I have learned so much about how to interact with this very special patient population. Our visits to our partner agency gave us the opportunity to see that the long term challenges for HIV patients go beyond visits to their primary care physician.

Our two part patient education series was very interesting. It reminded me how important it is to have agencies that not only provide housing and case management, but also provide a support group type of environment. All the participants were very attentive and eager to understand what our presentations meant for their management of HIV.

I was very pleased to have the opportunity to hear the perspectives of physicians working with the Chicago Department of Public Health, who highlighted the challenges of HIV patient care. Patient advocacy goes beyond the work we do in the clinic/hospital; it can benefit a much wider population by making changes in public health policy. Budgeting issues and other bureaucratic challenges may exist in the short term. However, in examining where we are now and where we were 15 years ago, we can see that our work in public advocacy has translated into more funds being allocated to medical research and insurance coverage for HIV patients.

Overall, my preceptor organized a great program. This program will have an impact on my choice of specialty and how I will positively impact patients with HIV.

Chris Ferguson
2010–2011 M2 PCM Scholar

A Safe Learning Environment is Key!

This year in the Patient-centered Medicine (PCM) Scholars Program, I had the opportunity to work with patients living with HIV and AIDS. I chose this field over the others because it is one of the patient populations with which I have not had much experience. Before starting medical school, I had worked in the mental health field, with homeless and very low-income women, and with immigrants living in the Chicago area. I had many rewarding experiences and learning opportunities while working with these underserved populations and I was excited for the opportunity to work with patients with HIV.

Our group collaborated with a community agency; a housing establishment for people living with HIV and their families located in the North Lawndale neighborhood. The services and support that they provide to the community are invaluable. I have learned that it is so important for people living with HIV to have, at the bare minimum, stable housing and a readily-available support system. These are some of the things that instill the confidence and motivation that they need to be able to take care of themselves and their families.

We were able to hold several group learning sessions with the clients at the agency. These sessions are what struck me the most. I was very surprised with the amount of interest and participation from the clients. On several occasions, they let us know how much they appreciated us being there and how much they looked forward to our next visit. I was also surprised at the varying degrees of knowledge they had. We each gave short, simple presentations on topics of interest, such as HIV medications and common co-infections, and opened the floor for questions and discussion. I think what the clients appreciated the most was the

opportunity to learn a little more about their disease and to ask questions in a safe and friendly environment.

Overall, I think that this is the most important thing I have taken from this experience: it is so important to provide a safe learning environment for your patients, no matter what population they may represent. By learning how to effectively communicate with them on their level, you allow them to feel comfortable enough to express their own opinions, concerns and questions.

Cassie Montoya
2010–2011 M2 PCM Scholar

Breaking Bad (News)

Throughout the course of life, it is interesting to see which experiences can affect and influence you the most. Sometimes the experience in question doesn't even have to be your own, but rather simply an overheard story that provides greater-than-average food for thought.

A case in point is a story told to me by a patient at the beginning of the school year. About ten years ago, this patient was having concerning symptoms and went to his doctor to get to the bottom of it. Labs were ordered and the patient was called back to the office once the results came back. Once seated in an examination room, the patient wondered why he was called in. His doctor entered the room brusquely and stated something like this: "In life, everyone has good days and bad days. Today, unfortunately, it is your turn to have a bad day." The doctor then pulled out a piece of paper, scribbled the word "AIDS" on it, folded it up and handed it to the stunned patient. The doctor then stated that he was busy and would be back to see the patient in five or ten minutes.

I was horrified when I heard this story. Surely it never really happened, I thought. It must have been pulled out of a psychological horror novel or possibly an episode of the Twilight Zone. The tactics used (or lack thereof) were harsh even for the show 'House'.

But it did happen. And I can only imagine how confused and frightened the patient must have been to receive this news in this manner.

After hearing that story and slowly digesting it over the course of this year, I can say one thing with certainty: I will do whatever it takes not to be or to become that doctor.

Corey Thompson
2010–2011 M2 PCM Scholar

Impact of HIV/AIDS amongst African Americans and My Experience in the HIV/AIDS Concentration

HIV/AIDS in America:
Although African Americans make up only 13% of the total U.S. population, they accounted for 48% of HIV/AIDS cases in 2007 (HHS, Office of Minority Health).

HIV/AIDS in Chicago:
African Americans make up 36.8% of the total population in Chicago, however, they accounted for 55% of the HIV/AIDS cases in 2006 (Chicago Dept of Public Health).

Impact HIV/AIDS Concentration made on me:
Hearing about and being involved in a crisis, such as HIV/AIDS, are two different things. The above statistics clearly indicate the huge impact HIV/AIDS has made on the African American community both nationwide and locally. My experience working with clients impacted in various capacities by this illness has been life changing. Not only did I realize how much a person's life can be affected, but also how much their family can be affected as well. This is not an illness that exclusively impacts an individual, but all of us one way or another. On the flip side, I also learned firsthand that a person impacted by HIV/AIDS can experience a normalized life with the proper support system and sustainable programs. We were privileged to work in conjunction with our community partner and African Americans infected with HIV. Due to the urgent need regarding HIV/AIDS in this population, I have decided to work with underserved populations to help stop the spread of this virus and slow its progression.

Laurine Tiema
2010–2011 M2 PCM Scholar

"I was so scared my kids would have my disease. But praise God that He saved them."

She bragged about her tall and handsome son, and how well he was doing in high school. Then her daughter walked in to the living room area, and she started to boast about her.

Katie* had invited me to her home earlier in October to meet and sit down for the first time. I guess it was more comfortable for her to talk about her HIV diagnosis in the privacy of her home.

Our Sunday afternoon conversation would have been classified as "normal". It could have been that I had met her in a café or at church and we had decided to get a little more acquainted with each other. There was nothing about her physique or demeanor to suggest that she was diagnosed nearly 20 years ago from an unknown source—she believes it could have been from either of two guys from her neighborhood. But when Katie began sharing with me her hope that she may one day be comfortable to open up to her church about her diagnosis, we both became still and silent.

This was the church that she grew up in. But she chose not to tell anyone because of the disease's stigma. She feared her friends' perception of her would change. In 2012, the stigma is still tangible and real despite the wealth of information we have. Despite all the medical advances, people may still believe HIV is transmissible by coughing or sneezing on them, like the flu. We, as the new faces of the medical community, may understand and learn about new medications being researched and discovered, but the advances are not spreading as quickly to the community as the patients hope. As in the 1960s, there is sadly (still) a true and present stigma of HIV.

* The patient's name has been changed to protect the identity of my continuity patient.

Rhonnie Song
2011–2012 M2 PCM Scholar

Mr. B has continued on as my patient during my second year of medical school. The process happened naturally; we just kept interacting. Despite our busy lives, I have been fortunate that Mr. B and I have been able to develop a professional relationship grounded in a sort of friendship. I assume it is a friendship, because at this stage in my studies, I am confident that it is not my intimate understanding of medicine that sustains our relationship. Recently, Mr. B came to our appointment with a small gift for me—nothing extravagant, just a small green book on surgery from the 1950's. Mr. B. picked up the book at an estate sale, because he saw it and thought it would help me. I can't quite explain how this made me feel. My patient was out, living his life, and he thought of me. He bought me a book to help me. Gratitude and humility come to mind.

I have always known that I aspire to be the sort of physician that builds relationships with my patients. But reflecting on this, it was always one-sided. What I mean is, I always figured knowing more about my patients would make me a better doctor, more able to help. What I neglected to recognize was the extent to which our patients let us into their lives, and help us right back. Mr. B's gift reminded me that, at the end of the day, our patients are just as important to us as we are to them. If we show up, so will they. If we take the commitment seriously, our patients will do the same, and will hold us accountable. I am so thankful to have had the opportunity to continue my relationship with Mr. B. for these two years, and I look forward to extending it throughout my time in medical school.

Daniel Savage
2011–2012 M2 PCM Scholar

HIV

Hi-5, down low, positive
Words to describe, words to attempt, words that fail to grasp
The importance
Test taken, two weeks waiting, breath held
For results
To tell her what
She already knows
How to cope, how to tell, how to live
When
Suddenly nothing is the same
And probably won't ever be
Just breathe, she says
To herself
Always to herself
Now, forever to herself?
She has to wonder
If
She'll ever be loved
Again
Or if this status is now
Her partner in crime

Kaiyti Duffy
2011–2012 M2 PCM Scholar

This year was full of surprises for me. Being in the HIV concentration of the Patient-centered Medicine (PCM) Scholars Program, I expected to teach patients about their illness and work with them on how to best manage it. However, it seems the patients had far more to teach me—and each other. In my experiences with talking to patients with HIV, they were well informed of their diagnosis, what it means to their daily lives, and next steps for ensuring a long, prosperous life. It was inspiring to see their enthusiasm as they shared fact knowledge, as well as life lessons, with each other. My group and I were taken aback by the power of conversation amongst peers, as it relates to making health decisions and coping with diagnosis. Additionally, participating in the PCM program has allowed me to initiate and engage in conversations about health and HIV in a predominately African American community, where dialogue on these subjects is often not the norm.

As an African American woman and future physician, it was encouraging for me to employ the notion of "each one, teach one" amongst African American women who are HIV positive. Seeing someone from their own community who looks like them and can relate to the cultural barriers that can keep African American women from reaching their healthful potential may allow them to reflect on their own lives—as certainly was the case for me. In turn, hopefully, we will shape a new generation of well-informed, healthy African American women who make well-informed decisions about their health. Honest, open conversations with each other, as well as with their partners and doctors, would have an overwhelming effect on reducing the rates of HIV/AIDS infection. I only wish that we as physicians had more time—in and out of clinic—to engage in the kind of authentic dialogue that I think it will take to overcome the current devastating statistics.

I was quite alarmed that HIV is five times more prevalent among African American women than previously thought. Sixty-six percent

of new HIV infections of US women occur among African American women—even though they only constitute 14 percent of the US female population. The CDC attributes this crisis to social and environmental factors that place African American women at a higher risk for HIV. Fortunately for me, the PCM program has not only taught me the importance of taking these factors into account as a future physician, but has also allowed me to be part of the solution through patient education.

Bryttney Bailey
2011–2012 M2 PCM Scholar

Homelessness

"Who am I?"

I am what you make me.
I am a great equalizer.
I am a condition common to both women and men.
I am present in all 193 (internationally-recognized) countries, Vatican City, and 10 de facto states.
I am present in all seven—yes seven—continents.
I am different (legally), yet the same in all of these countries.
I speak every language known to man.
I have been present with man from the beginning of time.
I—since 1987—have been addressed by MVR: Introduced by McKinney-Vento. Signed by Reagan.
I strip people of their identity.
I am usually present in major cities.
I am an invisible problem, yet I am very visible.
I am caused by wars.
I am caused by natural and man-made calamities.
I am caused by faulty economic policy.
I am caused by lack of access to health care. I cause lack of access to health care.
I am caused by unaffordable health care & bankruptcy.
I am caused by mental illness, substance abuse, domestic violence and the prison system.
I am a chronic disease. I cause chronic diseases.
I am, as they say, where the heart is NOT.
I afflict more than 2.5 million Americans. One-fourth of them are Veterans.
I afflict the mentally ill.
I afflict the (formerly) rich, poor, and middle class.
I stay with many people for as short as one month.
I stay with others for years to decades.
I have been most heavily afflicting children and families since 2002.
I have been used by companies to exploit my victims.

I have been criminalized.
I have been caused by bursting bubbles.
I give my victims a coat of stigma that few of them learn to take off.
I increase hospital length-of-stay by 36 percent.
I prey on the marginalized.
I reduce life spans. The average life span of my victims is 45 years.
I cause death. Age-adjusted death rates of my victims are 5-31 times those of the general US population.

Nevertheless,
I am a face you have all seen.
I am as visible as you decide to make me.
I can be beaten, with enough gumption, funding, good science and smart policy.
I am what you make me.
I am...Homelessness.

Badewa Fatunde
2010–2011 M2 PCM Scholar

"You Mean T-Helper Cells?"

One thing that I took from my experience this year in the Patient-centered Medicine (PCM) Scholars Program is to never make assumptions about the patient you are treating.

This year I had the pleasure of working with the homeless population. Initially, I was unsure about how to approach this novel situation. I had never been to a homeless shelter or talked with a homeless person, and as with every new situation that we encounter I had some anxiety. We were set to give a group presentation about sexually transmitted infections (STI) to a group at the shelter, and I think everyone was unsure about the patient's level of education on the subject.

We started with very basic information, going over common myths regarding STIs and eventually moved on to talk about individual diseases. During the AIDS presentation, we were explaining to the group that HIV/AIDS affects your immune system, and a certain cell type in your body that helps fight infection will decrease if medications aren't taken appropriately.

That is when one of the residents of the shelter spoke up, "You mean T-helper cells, right?" We were all in a state of shock for a brief second; how impressive that someone in the crowd knew about T-helper cells and their role in HIV/AIDS.

That moment is something that I will never forget about PCM. It taught me to never make assumptions about a patient population, and to treat every patient as an individual that brings in their own unique experiences and knowledge.

Nathan Stackhouse
2010–2011 M2 PCM Scholar

The Decision to Change a Life

As the first year ended and the call was sent out for rising M2s to choose Introduction to Patient Care options for the coming year, the option that was the most appealing to me was the Patient-centered Medicine (PCM) option. It was a delight when the assignments were made and I discovered that not only did I get my desired option, but I'd also be working with the Service Learning Program (SLP) for the year.

At the SLP orientation, I was assigned to the Homelessness concentration and met my group's preceptor. I also had the chance (all of us second year students did) to meet with the Interim Executive Director for the community agency we'd be working with. The work we as students would be doing was explained to us, and with this came perceptions, at least for me, of what I thought the homeless community at the shelter would be like. I also immediately formed perceptions of the role of agencies in providing services to homeless individuals.

It did not take long for my conceived perceptions to be torn down. The first step in the tearing down came as we made our initial visit to C-House—the supportive housing for homeless adults and single parents recovering from substance abuse, run by the community agency. During that visit, the interim director helped us to see that the mission of the agency was to help individuals within this vulnerable population take control of the steps to turn their lives around. The strategy seemed to be that if a stable home was provided, people can then be expected to pay attention to the underlying challenges in their lives. The message to the community was this: we will be a part of your lives, but we also need you to be a part of your lives. In other words, we want you to succeed, and we will do everything we can to help you along that journey, but we need you to be a willing participant.

Through health fairs and sessions we met with the residents of C-House. Again perceptions, which were preconceived, were torn down. The typecast of the homeless individual was nothing close to the men and women we got to meet and interact with. In topics that made up our conversations, they seemed in some instances to have more insight than one would perhaps associate with them. The range of folks we met went from a gentleman who was a few credit hours removed from a psychology degree to one who was in the workforce as a school bus driver.

So many lessons were learned at the end of this experience. I will share a few that I hope will stay with me in my walk through life. Those of us being trained in the call to serve as physicians must keep in mind that we cannot do all things, we cannot solve every problem, but those things which we can do, must be done with consummate dedication.

The shelter we worked at came to be in the 1920s through the response of a local pastor. He began first by providing food and clothing to the poor, homeless and hungry of his community and eventually the charitable work included treatment for people struggling with addiction. Just as in the 1920s, the poor, hungry, homeless, the helpless, and many in despair live amongst us. We must live awake and aware just as he did and we mustn't be afraid to respond. Finally, at times, especially in our world of healthcare delivery, there is nothing easier than taking sole ownership in the process of healing an individual. I think the invitation instead, as we see in the approach of agencies like the shelter, is to trust and invite people along the path to bring them good health. This is one way to nurture the dignity of our patients. At the end of day, when the last voice has been heard, only one person can make the decision to change a life and that is the individual to whom the life belongs.

Junior (Jerry) Nwobodo
2010–2011 M2 PCM Scholar

Misunderstood

There are dark whispers being drowned out by the bustle of the city.
The trains, sirens and car horns conceal the true identity most people find taboo.
Ignorance.
Daily there are biases and prejudices practiced among each other.
The stares from passers-by are colder than the concrete supporting the even colder feet of the beggar on the receiving end of those stares.
The assumptions are created in our minds of an inferior people, as if inhuman.
The color of their skin might be different, the odor and appearance repel us like magnets.
We'd like to think ourselves a humane and caring society and yet we treat our own like animals.
Kicking them when down.
Spiting on their already rain soaked faces.
And yet sadly we wouldn't actually treat our animals that way, would we?
Ever heard the story of a homeless?
Any homeless, choose one, there are plenty.
The people behind these stories have been through hell and back.
They are you and me.
College graduates, Husbands, Mothers, the Disabled, Veterans, Children.
And like us, like anyone, are equally if not more misunderstood.

Rashell Reynoso
2010–2011 M2 PCM Scholar

When I found out I was assigned to the Homelessness concentration, I had concerns about exactly how I would be able to accomplish the mission of the PCM Scholars Program with the homeless population. How in the world could I establish continuity of care with a patient who did not have a stable living situation? The homelessness concentration allowed me the opportunity to reconsider my definition of what patient-centered medicine really was. It is about delivering the care that your individual patient needs at that moment. Today might not be the day to address a long smoking history. Instead, it might be the day your patient just needs someone to talk to about the struggles of being homeless and having children. While working at the shelter, we treated not only the acute problems of the patients we saw, but we attempted to heal the soul as well by being compassionate and lending an understanding ear whenever necessary.

Many of the patients were frustrated by other encounters they had with physicians. They had been denied care, forced to wait for long periods of time, not taken seriously, and prescribed drugs and treatment plans they did not fully understand. I found that many of the patients had chronic problems for which they had previously received care, but were not compliant with the physician's recommendations. Most of the time, it was because they felt the physician did not sit down and explain to them why this treatment plan was better than others in terms they could understand. This made patient education extremely valuable to me during patient encounters. Something as simple as pulling a diagram of the spine up on my cell phone to explain why a patient was having back pain went a long way towards making the patient feel more confident about a given course of treatment. The patients seemed very appreciative to have someone who they felt listened to them and tried to adapt to their needs at the time rather than assuming to know what's best. We were able to gain the trust of many of the patients we saw. It felt good to restore some of their hope in the medical field.

I learned a great deal about myself while working with this underserved population. I learned the importance of putting yourself in your patient's shoes. I learned that my previous view of what it meant to be homeless was a stereotypical one. Most of the patients I saw were more like me than I expected them to be. At times the work was challenging because of the access issues these patients face. But without physicians and other health professionals to advocate for this group, they tend to become lost in the system. My advice to future students in this concentration is to go in with an open mind and realize that the challenges you face are far surpassed by the reward you feel by helping those in need.

Breana Taylor
2011–2012 M2 PCM Scholar

Homelessness ≠ Helplessness

We all know the image of the cardboard sign, tattered clothing and the weather-beaten brow. But we do not know their story, where they come from or who they really are.

I didn't have many expectations going into our project with a local shelter, besides anticipating tremendous obstacles in caring for homeless patients. So I met my first patients in the basement of a church in between their breakfast and showers, and let them say what they wanted to say. And I listened.

There is not much we can do as second year medical students besides listen. I allowed my patients to set the agenda and let their stories unfold at their own pace. Perhaps more than any others I've encountered, these patients were forthright and earnest about their life and health. And though the options for care are fewer, almost everyone I spoke with had a plan for where to go if they needed treatment or medicine. Usually, this was the Emergency Room at the county hospital, where they will wait dutifully for hours to get a supply of blood pressure medicine that will last them until the next month when they will make the trip again. No refills.

I was overjoyed when I saw both my patients at our second visit, and again at a third. Continuity was certainly not one of my expectations. I checked in about their progress since our last visit and one patient is really thinking about quitting smoking and entering a rehab program, but isn't quite ready yet. We talk about the obstacles to quitting and what it might take for him to at least cut back. And for now, it is enough. The rest of the time we talk about his kids; his youngest son just turned 10. It is an honor to share in his joy.

Like all patients, homeless patients have some good habits and some bad ones. And like many of us, they have finite resources and

must set priorities. My particular patients were more fortunate than many of the other homeless patients. One had a monthly disability check, and the other was a Veteran of the US Army. It was possible for the former patient to cut out one pack of cigarettes per month in order to get a $4 prescription with refills that we could write on the spot to save him a few daylong trips to the ER. But he was not ready. The latter patient we provided with a transportation pass to the VA for evaluation of painless blood in his urine, and called VA patient services to make sure he could visit the ER anytime, day or night, to re-establish his care. But he would not go.

Like all our patients, and much like you or me, homeless patients make autonomous decisions about their health. And they deserve the same respect and non-judgment that is afforded to anyone else. In spite of their challenges, my patients are resilient and resourceful. They are also human. And like all our patients, we must meet them where they are.

My patients have taught me that homelessness is not helplessness. Or hopelessness.

We are all more alike than we are different.

Darcy Benedict
2011–2012 M2 PCM Scholar

Mother

Mother- I think to myself. *She's a bit tired maybe, but calm… friendly. Good first impression.*
She regards me with a smile. I offer her a seat.
"Thank you for coming today. I'm a student doctor…"
Pleasantries.
"So what brings you to see me today?"

CC: "Joint pain" I jot down as a chief complaint.

O-	Increased clumsiness		Female (get DOB)			
L-		n		Memory problems		
D-		o	Fall on bus (9mo ago?) (6 mo?)	Headaches	n	
C-	Family Hx: DM,	mHTN, HL		AM	o	elbow
A-		e	Maybe vision change?	NKDA	E	
R-	rt. hip/thigh	d	Pain radiates, achy, ~~7/10~~	9/10@worst	T	ØPSH
T-	vision change- new glasses, repeat optho?		Completing classes- Childcare manager		O	
S-	1 son, adult, ? y/o, no known med probs.		decreased strength!		H	

My attending walks over. I scribble more notes as quickly as I can and look up.
"How are you doing today?" she addresses the patient.
"Oh fine doctor. But I've started having seizures again. I hadn't had one for more than 20 years."
SEIZURES?
S%#*
She didn't tell me that. Now I look stupid.

CC: ~~"Joint pain"~~ SEIZURES. I revise my notes.

The encounter is nearly over. I'm mentally drained. *Oh, Oh, Oh, To, Touch, And, Feel, Very, Green, Vegetables, Ah, Heaven. Which one is cranial nerve seven again? Oh, Oh, Oh…*

The attending asks me to test the cranial nerves.
$&%*
More time oozes past.
"Let's get some contact information and set up an appointment for a head CT."
Good. I can do this.
I turn to the patient.
"What would be the best way for us to get in touch with you? The doctor would like to order an imaging study of your head."
A blank look.
"Well"
A long pause…
"I'm staying at a shelter right now… I'll be there for another two weeks…. You see, my apartment burned down a few months ago. I didn't have insurance. It was a miscommunication with my son was all. I stayed with family and friends for a while. But… yes, you should call me at the shelter for now…"
My stomach drops. Reality hits me. *Oh, geez...I've just been the most self absorbed jerk.*
The next day I contact a center which agrees to perform the CT on a sliding price scale. I call the shelter with the good news, but I never hear back.
This is October in Chicago. It's going to be getting colder soon.

To this day, I don't know how she is doing with her seizures. I called her voicemail at the shelter several times and begged for her to call me back. But the two weeks passed and the voicemail no longer goes through. I imagine that she was forced to move on once again. Maybe to the couch of a caring friend. Hopefully not to the streets—certainly not with uncontrolled seizures or a potential tumor. I pray that she doesn't have a tumor.

I can't imagine facing a tumor if I didn't even have a home.

Patricia Troxell
2011–2012 M2 PCM Scholar

Immigrant & Refugee Health

Approaching the Refugee & Immigrant Health concentration group, I felt confident in my abilities as a transition point between the patient I would be assigned and the medical realm that would have to be navigated with them. Upon my initial meeting, I realized that the practice of medicine in conventional terms would have to be expanded. The family I began working with arrived from a country afflicted by external and now internal conflict that drove them to depart. Arriving in Chicago, they found themselves enmeshed in employment situations that did not utilize the skills the family members had been trained in in their country of origin. They have found themselves alienated in more ways than one within the sociocultural framework of U.S. policy. From that original conversation, I found that my ability to serve as a patient liaison needed to undergo a metamorphosis of sorts. I could not simply address my family in the context of isolated medical problems.

The Patient-centered Medicine Scholars Program often stresses the practice of the social aspects of medicine; approaching the patient in a more holistic way. In the setting of my family, I realized this to be even more the case. Perhaps my biggest frustration throughout the year has been my inability to fully address this larger, fundamental issue. While the immediate health problems that brought my family to the United States are in the process of being addressed, the underlying experience of being refugees continues to impact them, most likely affecting their health outcomes as well. It is this ongoing cycle of stress and worsening physical and mental well-being that I believe ultimately needs to be brought into the fold of medical treatment for these communities.

Angel Desai
2010–2011 M2 PCM Scholar

Chris, a 14 year-old African American boy, after his father lost his job, had to move from Memphis, TN to Elgin, IL, a suburb in the outskirts of Chicago. It was depressing for him to be taken out of the only neighborhood he knew, and from all his friends and family. Moreover, this area in Elgin he was moving to was predominantly Hispanic. People spoke differently, dressed differently; most people had their own cliques they formed in middle school. He was clearly an outsider, who spoke different, acted different and looked different. At home, his parents were struggling at settling into this new city and into their new apartment and his dad was struggling with his new job. Chris was at a loss.

On a Monday morning, while sitting in Algebra class, Chris thought to himself: *As much as this class puzzles me at times, in comparison to my life, it is much clearer. It has logic and there is always an answer, there are basic principles and rules, whereas in my "new" life, there is none.* However, on that very same day, someone heard Chris's call of desperation. It was fate that a kid who had also moved from Memphis, TN sat across from Chris at lunch. Chris finally met someone who understood him, his way of talking, and his values; all of a sudden, a void was filled for Chris; he had finally found his bridge to his new home.

In my experience, the community agency we worked with is that friend and that bridge for the immigrant community. The realities of our world are harsh; the people I met at the agency were forced to leave their homelands not to simply find a job, but to preserve their lives. People didn't only talk differently, they had a different language. They lacked moral support; they had health insecurities as well as financial insecurities, not only for themselves, but also for their children. For them, the agency is not only a friend, it is their life line.

Security, in the most basic sense of the word, is something that everyone has a right to have. Understanding the importance of

having this security, the issues of the immigrant community became a priority for me, as one should love for others what he/she loves for himself. Patient-centered Medicine (PCM) gave me this gift; it made me aware. Moreover, this experience allowed me to experience what my immigrant family experienced directly when they visited their health care provider; it allowed me to understand the challenges of the providers in providing care for this population; and allowed me to understand the political challenges that organizations face in securing this support, this lifeline, to the immigrant population. As a future physician, working with different people, organizations and coalitions to build "bridges" will be as much of a priority to me as practicing my day to day medicine.

Author's Note: *The story of Chris is fictional; really a story similar to mine. It is meant to allow the reader to develop a connection for understanding the refugee/immigrant experience. I use Chris's story to relate the reader to the somewhat more extreme lives of the immigrant families we worked with in the PCM Scholars Program.*

Osamah Abdallah
2010–2011 M2 PCM Scholar

Our health care system—an automated message?

It might be that I should have guessed the confusion to ensue when I was sitting next to my preceptor in the living room of a refugee family one night in early October. Our partner community organization had provided us the briefest of details about the patients with whom we would be working. I knew my patient's contact information and that he had a back problem and could not work. After getting to know the family and talking about the Service Learning Program, I began to shift the conversation to my patient's health problems, specifically his bad back. I thought it best not to come out and ask so I tried to hint in hopes of getting him to open up. I quickly discovered that he had no back problem and, in fact, had been working at a local grocery store for some time. At this point, I looked over at my preceptor. He looked back at me. I had the feeling one has when one discovers that he is in the wrong house, talking to the wrong family, asking questions about the health of the wrong man.

I must admit that I did not verify the patient's identity thoroughly during the initial phone call. I had asked his name, he had said yes and I proceeded to set up the meeting.
Fortunately, my patient (who was not actually my patient) had a twelve-year old son who suggested that we might be interested in meeting his uncle who had a back problem and could not work. This was my introduction to the world of refugee health.

When I met my patient, Zang*, for the first time, he was nervous and excited since he had received an automated message from the county hospital telling him that he would be receiving neurosurgery in approximately two weeks—something for which he had waited a long time. I was tremendously happy for Zang since his back pain had severely interfered with his ability to work and establish a life in Chicago, his new hometown after migrating from his home country. Zang agreed to let me accompany him to the hospital on

the day of the surgery and I promised to meet him the night before to help calm his nerves and answer any questions he might have. That night, he was noticeably worried. He had been having trouble sleeping for the past week and asked question after question about the surgery, pain level and the recovery timeline. I did my best to reassure him.

On the day of the surgery, I should have guessed that something was wrong when the nurse asked Zang if this was his first visit to Stroger and I shook my head as he said yes. It turned out that it was his first visit and there would be no neurosurgery for him that day. The resident we saw wrote him a prescription for Physical Therapy (PT) and told us to return in two weeks with the disc of the MRI that had been done when his insurance was covered as a new refugee to the U.S. As we walked out of the hospital, Zang was quiet. I was stunned. What does someone say in that situation? I worried that I had contributed to the misperception, that I should have asked him more about his preoperative care, that I had failed him in some fundamental way.

When we returned two weeks later, a different resident reviewed the MRI and said definitively that there would be no neurosurgery. He also said that he would refer us to the Musculoskeletal service. I explained that we had already been referred to PT. The resident said that this would override that order. When we spoke to the scheduler, we learned that we needed to see a primary care physician before we could be referred to Musculoskeletal. At this time, no primary care appointments were available. The clerk was unreceptive to my explanation that we had already received a referral from the Neurosurgeon.

"Expect an automated message," she said. Instead of getting an automated message to see a primary care physician, Zang got one for Physical Therapy. Again, in the days before, he was nervous and restless. I tried to explain the concept of PT and put his mind at

ease. When we arrived, however, there were no exercises to be had. Instead, an instructor explained that the hospital had one, that's right, one Physical Therapist for the entire outpatient service and he received 300 referrals per week. Only the most severe cases got PT. My patient and the 25 other people sitting in this second floor classroom did not fit into that category. A three-hour session on how to "live" your life with back pain ensued. That was all the PT that my patient would receive.

Afterwards, I apologized to Zang and tried to explain what had happened. Once again, my understanding of the way the healthcare system works in this country was undone. Once again, I felt the incredible impossibility of my task to help my patient get the care he needs. If I, a seemingly competent and fluent English speaker, in medical school, cannot help this poor man, what becomes of the thousands of people who lack advocates, who can't call and badger hospital clerks, who lack anyone with any understanding of the system? What becomes of them?

We're still waiting for the automated message from Musculoskeletal.

** Names were changed to maintain anonymity.*

Benjamin Carney
2010–2011 M2 PCM Scholar

This year, I worked with a refugee from Africa who had chronic back pain. I met him a few times at the community agency, as he was taking English classes there, but was never able to visit his home or meet his family. This was because it was nearly impossible to contact my patient. For one thing, he had no cell phone or house phone. For another, he gave me the number of a friend's phone which had already been disconnected. And lastly, he did not really understand much English. It took most of the year to organize those few meetings and had to use the agency staff as go betweens.

My patient had been a refugee in the US for over 6 months. This means that the agency no longer coordinated his medical visits; he was on his own. If I, a medical student with a decent amount of time on my hands, could not get a hold of this one patient, how are his doctor's, who deal with multiple patients, supposed to? How will he get medicine or tests to improve his constant everyday pain when he doesn't understand what's going on or where he needs to be or when he doesn't speak English? I am not blaming the agency; they are beyond swamped with the amount of refugees they deal with everyday and they do an amazing job keeping track of the untraceable. My patient is by no means alone; his situation is by no means unique.

This experience has made me realize how easy it is to be "lost to follow up" and how important it is to try to prevent that.

Elizabeth Messer
2010–2011 M2 PCM Scholar

For me, the Patient-centered Medicine (PCM) Scholars Program has been and continues to be about perspectives. It's easy to get lost in the details of our studies and the immediate pressure of exams and forget why we came into medicine in the first place: to help people and to make a difference. PCM helps me keep that perspective and serves as a refreshing reminder of the bigger picture.

When I was first looking into PCM almost two years ago, it was the Immigrant and Refugee Health concentration that clinched the deal. I've been interested in global health and working with this underserved population seemed a natural choice. I walked into this concentration this year with the hope that my year would give me more exposure to the health needs of this population.

What I got was so much more. Working with the kids at our partnering agency was a very poignant experience. It's staggering to think about what they go through, how they give everything up for just the smallest chance of a brighter future.

What moved me more was the general demeanor of the kids at the agency. They were so carefree. We examined two brothers the last time I visited the agency. Watching one of the kids happily play with my stethoscope, you wouldn't imagine that just two days ago they were being smuggled into the country all the way from Honduras in the back of a van.

Like I said, PCM is all about perspective I was hoping to help people in this program and hopefully gain something in return. I'm glad it wasn't a contest because I would have lost.

Sumanth Kidambi
2011–2012 M2 PCM Scholar

I Never Knew

I never knew. That's all I could think when I heard the stories of the patients I worked with this year as a member of the Immigrant & Refugee Health concentration group in the Patient-centered Medicine Scholars Program. I couldn't believe that there was such a unique, underserved patient population in the Chicagoland area that I never knew existed. While I have always wanted to work with diverse populations and hope to embrace the challenge of overcoming the linguistic and cultural barriers to health that such groups faces, I never realized the large number of refugees and immigrants in my own backyard who had been forced to come to the United States due to dire economic and sociopolitical reasons in their native countries. I never knew that, in the city of Chicago, there was such a large population of people with such amazing stories of courage, resilience and hope.

My first encounter with this special group of patients was on a warm October evening. Brimming with curiosity and a bit of nervousness, I arrived at an apartment complex, unsure of what lay before me. Having attended an orientation session at an organization that helps refugees assimilate to the United States, I had been assigned a patient who I had heard survived war and sociopolitical conflict in her native Iraq. While I had spoken to her son briefly on the phone, I wondered how difficult it would be to communicate with my patient. I wondered if she would share her struggles with me, whether she would trust me enough to share her medical concerns, or whether she would be shy and unwilling to talk. I shouldn't have worried. Over a cup of steaming Turkish coffee, my patient shared with me the struggles she faced as a new resident of the country; like the fact that she and her husband, who had suffered a gunshot wound from the violence in Iraq, took multiple buses and many hours to get to each doctor's appointment. She showed me letters from the clinic she visited, typed and mailed to her, that she could not understand. Her husband described the miscommunication problems he faced—while he had been waiting months for a dentist appointment, he had received a letter stating that his dental healthcare was being cancelled, allegedly based on his request. As they shared their experiences, I could not help but wonder what it would be like to be in their shoes, to have survived so much, to escape to perceived safety, only to be met by barriers to basic healthcare.

Yet these patients were not the only inspiring examples of perseverance I met this year. I was yet again amazed to find that there is a large population of child refugees living in Chicago, children often no more than 10 years old who had traveled treacherous roads with dangerous people to work in the United States and send back money to their families. In some cases, these children came to the United States alone, braving train rides where they could easily be attacked, and harsh weather conditions, to join their parents who had already migrated to the United States. In other cases, these children had been sent through smugglers, who were promised huge sums of money by their families so they could send their precious children to the United States in hopes of a better life for the next generation. These children would sometimes call home and hear that yet another member of their families had been killed because their family could not pay the money they owed the smuggler. I was privileged to be able to attend clinic visits with these children, and as I performed physical exams for abdominal aches and asked them about their medical history with my limited Spanish, I marveled at the strength that these seemingly frail bodies must hold. Yet despite all the challenges they had undoubtedly faced, they were still children, who gleefully practiced English phrases with me, asking if they had said them correctly and wincing when they saw the gleam of the needle as I gave them their immunizations. So far from their families and from the comforts of home, they were willing to trust, eager to learn, and able to smile—and these are perhaps the greatest challenges for all.

I never knew, but now I do. I am so grateful for the opportunity I had this year to expand my perspective on the patient population in this great city of Chicago. Speaking with these patients, both old and young, gave me insight into the struggles and needs of refugees. They have made immense sacrifices to make it to the United States and deserve to be given quality healthcare, with sensitivity to their language, culture and personal experiences. I hope to one day be an advocate for such individuals through my work as a physician. I hope that our healthcare system will fulfill the hopes of safety and security they had when they traveled here. It is up to us all to work to give them that basic right.

Ivy Abraham
2011–2012 M2 PCM Scholar

This year I had the pleasure of working in the Immigrant and Refugee Health concentration of the Service Learning Program. I was assigned a patient who is an Iraqi refugee. Before starting this program I had an idea of the types of stories I might hear from my patient and I thought I was ready. Then I had my first meeting with her. She was a small elderly woman with a smile on her face. She looked like the prototypical grandmother and she acted like it as well. She really wanted to know how things were going for me in medical school and she was so happy when I told her I had children. She told me she loved children and that she was a teacher for almost 30 years in Iraq before the war. I then started to ask her about her life and how she was adjusting to living in the United States. She told me she was very grateful for having the opportunity to come to the US and for having an agency to help her in the transition. But when she mentioned Iraq her smile was quickly replaced by sadness and worry. She told me that her sister was murdered and that she had received constant death threats in Iraq. She felt the only way to protect the family she had left, including her sister's children, was to flee with them to Jordan. I found myself trying to comfort her while not letting my own emotions overwhelm me.

I also visited an agency that served undocumented children who are waiting for their case to be decided by immigration officials. There I met two brothers from Honduras who were 3 and 7 years old. They were basically the same age as my own children. I couldn't help but think, how bad must things be in their homeland that their parents thought it would be better to send them to the US unaccompanied than to stay by their side. My heart went out to the children as well as their parents. As a father I can only imagine how heartbreaking that decision was to make.

Working with patients like these is exactly what I want to do as a physician. But I have to admit that I was unprepared for the emotional toll these experiences might take on me. I am grateful to have participated in the Service Learning Program and for having had these experiences early in my career. I grew so much this last year primarily because of the interactions I had with my patients in this program. I only hope that I prove worthy of the contributions they have made to my education.

Luis Rivera
2011–2012 M2 PCM Scholar

2010–2011
M1 STUDENTS

Ivy Abraham
Neha Agnihotri
Amanda Allison
Darcy Benedict
Bryttney Bailey
Angela Bixby
Mateusz (Matt) Ciejka
Michael Charles
Thomas Chen
Shan (Susan) Cheng
Nicole Diaz
Khushboo Doshi
Aaron Goldstein
Robin Holmes
Thomas Hatzilabrou
Ruth Hsiao
Can (Angela) Jiang
Sumanth Kidambi
Innessa Kipnis
Sonny Patel
Anisa Rahman
Jacqueline Restrepo
Faith Rohlke
Daniel Savage
Elizabeth Shay
Rhonnie Song
Jenna Spencer
Breana Taylor
Thalia Torres
Patricia Troxell
Crystal Unzueta
Stephanie Wang
Dawen Zhang

M2 STUDENTS

Osamah Abdallah
Sarah Anderson
Carmen Cancino
Benjamin Carney
Meenadchi Chelvakumar
Celeste Cruz
Angel Desai
Olubadewa Fatunde
Chris-Gerald Ferguson
Xochil Galeano
Rachel Guild
Dempsey Hughes
Anne Jennings
Elizabeth Messer
Cassandra Montoya
Junior Nwobodo
Yury Parra
Melissa Preyss
Rashell Reynoso
Nathan Stackhouse
Corey Thompson
Laurine Tiema
Yesenia Valdez

2011–2012
M1 STUDENTS

Mustafa Alavi
Jurgis Alvikas
Meagan Appleman
Geoanna Marie Bautista
Natalie Bodmer
Amy Brown
Ann Bruno
Melissa Bryan
Michael Donovan
Aqsa Durrani
Ashley Freyre
Lilian Gonzalez
Puja Gopal
Michelle Hwang
Tara Kennedy
Katie Kinzer
Jessica Kuppy
Marion Liu
Jose Marquez
Joshua Mendoza-Elias
Abu Okanlawon
Erika Olson
Shama Patel
Jie Qu
Rachna Rawal
Sabrina Reed
Sergio Sean Salés
Ann Schraufnagel
Lindsay Schwartz
Nikita Vashi
Christine Wang
Jacqueline Wulu

M2 STUDENTS

Ivy Abraham
Neha Agnihotri
Amanda Allison
Bryttney Bailey
Darcy Benedict
Leah Bruno
Edwina Chang
Michael Charles
Thomas Chen
Shan (Susan) Cheng
Khushboo Doshi
Kaiyti Duffy
Cassy Friedrich
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